



Report on the Feasibility and Cost-Effectiveness of a Consolidated State-wide Health Benefits System for Michigan Public School Employees

July 13, 2005

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July 13, 2005



Mr. John Strand
Council Administrator
Legislative Council, State of Michigan
P.O. Box 30036, Fourth Floor - Boji Tower
124 West Allegan
Lansing, Michigan 48909-7536

Dear Mr. Strand:

On behalf of the Hay Group we are pleased to present our report on the feasibility and cost effectiveness of placing Michigan public school employees in a consolidated state-wide health benefit system.

We find that substantial savings could be achieved through a state-wide health benefit system for public school employees. We considered three options that could save from \$146 million to \$281 million a year in 2005 dollars. We recommend an approach that would save \$281 million a year in 2005 dollars, but the full savings could not be achieved until all school systems were in the state-wide plan. The report fully explains our findings and recommendations.

The successful and timely completion of our report depended on quick and complete responses from your office, the school districts, and the many organizations with information pertinent to the study. We were provided with timely and complete responses to all of our requests for information. We wish to thank those who generously gave of their time to meet with us and provide us with their counsel as well as the information that we used in this study, including the administrators at hundreds of local school districts who completed the health benefits surveys.

We are available to discuss the report with those interested in the results at your convenience.

Yours truly,

Edwin Hustead, FSA, EA, MAAA

A handwritten signature in black ink, appearing to read "Edwin Hustead".

Adam J. Reese, FSA, EA, MAAA

A handwritten signature in black ink, appearing to read "Adam J. Reese".

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A handwritten signature in black ink, appearing to read "Tom Wildsmith".

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I. EXECUTIVE SUMMARY

Our charge

The Hay Group was retained by the Michigan Legislative Council to determine whether it is practicable and cost effective to place Michigan public school employees (employees of K-12 school districts, intermediate school districts, charter schools, and community colleges) under a state-wide group health benefits system, with clearly defined benefit levels.

The scope of the charge from the Michigan Legislative Council included:

- Analyzing the Michigan public school employees' current health benefits including medical, dental, vision, and prescription drug programs. This analysis will encompass premium costs, out-of-pocket costs such as deductibles, co-payments and co-insurance, and premium cost-sharing.
- Examining other considerations in establishing a new health care benefit system for Michigan public school employees, including the impact on collective bargaining for public school employees and the possible effect on the Michigan Public School Employees Retirement System (MPSERS).
- Examining the prospective benefits, particularly potential reductions in costs to both Michigan and local school entities, that might accrue as a result of placing public school employees under a group health benefits system operated by the State of Michigan.
- Providing an implementation plan outline, with the major steps needed to implement the new health benefit system.

As part of this report we were directed to seek input from group insurance providers and any other groups or individuals who may have information relevant to this study. Additionally, we were tasked with reviewing the manner in which other states provide health benefits for their public school employees in order to better control the growth in related costs.

Basic Approach

To address these issues, Hay put together a multi-disciplinary team of actuaries and health benefit specialists. This team performed a thorough actuarial analysis of the current health benefits provided by school districts in Michigan, examined the financing and operational aspects of establishing a consolidated state-wide plan, analyzed the potential impact on all of the primary stakeholders in the system, reviewed the lessons learned by other states, and developed for consideration by Michigan policymakers an implementation plan with sufficient detail to provide an understanding of the primary steps necessary to establish such a program. The key components of the study included:

- A survey of Michigan school districts, charter schools and community colleges (hereafter referred to as school districts) to understand the health benefits currently provided to school district employees. The questions in the survey covered enrollment, types of health plans offered, premium costs for those plans and financing approaches used, as well as employee contribution levels and plan management initiatives.
- Interviews with interested parties and others knowledgeable about the current system of providing health benefits to school employees in Michigan. Hay staff interviewed representatives of the following organizations:
 - Blue Cross Blue Shield of Michigan (BCBSM);
 - Michigan Education Special Services Association (MESSA);
 - Delta Dental;
 - Michigan Federation of Teachers & School Related Personnel (MFT);
 - Detroit Public Schools (DPS);
 - Michigan Department of Civil Service (Civil Service);
 - Michigan Association of School Administrators (MASA);
 - Michigan Association of School Boards (MASB);
 - Michigan School Business Officials (MSBO);
 - Michigan Employee Benefit Services (MEBS);
 - Michigan Public School Employees Retirement System (MPSERS);
 - School Employers Trust and School Employers Group (SET SEG);
 - AFL-CIO Employer Purchasing Coalition (AEPC);
 - International Union of Operating Engineers Local 547.
- Gathering data on the enrollment, premiums and administrative costs of existing sources of coverage;
- Reviewing other states' approaches to providing health benefits to public school employees;
- Analyzing the alternative design options available for a state-wide plan;
- Modeling the differences in costs and benefits between the current system and the primary design alternatives for a state-wide system;
- Analyzing the potential implementation issues associated with a consolidated state system.

Key findings

Based on data from the school surveys and aggregate financial data from the above mentioned parties, we estimated the total medical care cost for 190,500 school employees and their dependents will be \$2,165 million in the upcoming school year (July 1, 2005 to June 30, 2006). We estimate the cost for dental and vision benefits to be an additional \$150 million.

There are four types of health plan that cover Michigan school district employees. Traditional fee-for-service (**FFS**) plans permit the employee to select any available physician or hospital for treatment. Preferred Provider Organizations (**PPOs**) are networks that contract with the health plan to provide services at a discounted rate. Employees pay less for PPO network providers than for non-network providers. Point-of-service (**POS**) plans also use networks and require that patients have a primary care physician act as a gatekeeper to determine if treatment is needed. Health Maintenance Organizations (**HMOs**) require that all treatment be provided through their physicians and hospitals.

We conclude that a state-wide health plan for public school employees could, in the aggregate, have saved between \$146 million and \$281 million in health care costs during the 2005/2006 school fiscal year, out of an estimated total expenditure of \$2,165 million. The composition of these savings is shown in Table ES.1.

TABLE ES.1		
School FY2005/06		
	Total Medical Care Expenditure	Total Estimated Savings
	\$ Millions	\$ Millions
Current System	\$ 2,165	
Option 1	\$ 2,019	
Single Self Funded system		57
Centralized administration		89
Total		\$ 146
Option 2	\$ 2,010	
Single Self funded system		57
Move to Standard Plans		(39)
Centralized administration		137
Total		\$ 155
Option 3	\$ 1,884	
Single Self funded system		57
Move to Standard Plans		(39)
Savings from elimination of Fee-For-Service plan		108
Centralized administration		155
Total		\$ 281

Option 1 provides all employees with the same level of benefits as they currently have, and would have saved approximately \$146 million in FY 2005/06. The cost of a state-wide plan with the same level of benefits for all employees would be less than the total cost of the current plans for two reasons. First, moving to a single, self-funded purchasing system would reduce costs by \$57 million. Second, a tightly administered state-wide plan could achieve savings that are not available in the current diverse system. We estimate that the savings would be \$89 million. For instance, a state-wide system could monitor the eligibility of dependents better than is done for the current plans. The explanation and analysis of these two types of savings are included in Section IV of our report with details in Appendix C.

Option 2 is similar to Option 1, but greatly simplifies the administration of the program by defining a fixed set of benefit plans from which school districts could choose, rather than allowing each district to tailor a unique health benefit plan. Administrative savings increase from \$89 million to \$137 million due to the greater efficiency possible by reducing choices to a few plans. Since not all districts would find an exact match for their current benefits, there would be some changes in cost – both increases and decreases – as districts moved to the new plans. The size of those changes would be partially dependent on the number of plans provided, and their specific design. Because most districts provide benefits within a narrow range of value, we believe that two FFS plans, two PPO plans and one POS plan, along with the HMOs currently available, would meet the needs of Michigan's schools.

Standardizing the benefit offerings produces significantly greater administrative savings. Some employers would have further savings because the benefits selected for their employees would be less than under the current system. On the other hand, some employers would pay more for the new benefits. The net effect of the selection of a benefits plan would be an increase in cost of \$39 million. The total savings for Option 2 would be \$155 million compared to \$146 million for Option 1.

Option 3 is similar to Option 2, but eliminates the two FFS options. Most employers have moved away from FFS plans because network-based programs can provide comparable or more generous benefits at a lower cost through agreements with networks of physicians and hospitals. Most of the \$126 million increase in savings over Option 2 is the \$108 million resulting from the savings due to eliminating the FFS option. The total savings from Option 3 is \$281 million.

A description of the benefit plans under Options 2 and 3 can be found in Section V.

Table ES.2 shows the impact on school district employees of moving to a fixed set of standardized state-wide plans in options 2 and 3. Option 1 allows each local school district to maintain its current benefit plan unchanged so school employees would see no change in benefits. Under both options 2 and 3, well over half of all school employees would experience a change in benefits representing no more than 5 percent of the value of their plan. Under option 2, only 8.6 percent of school employees would see a benefit reduction of more than 5 percent. Almost nine out of ten (89 percent) would see no change or an increase of 5 percent or less.

Option 3 has two effects on the benefits to employees. First, there is a change in the benefit design. In many cases, the new PPO benefit design will be an improvement over the FFS benefit design. The result will be to reduce the number of employees who will have a lower benefit and increase the number with a higher benefit. That effect is shown in table ES.2.

The second effect is that the employees, and their dependents, will have to use a network physician to receive the higher level of in-network benefit. This might be perceived as a reduction in benefit. About half of the employees would move from a FFS plan to a PPO plan under Option 3.

TABLE ES.2		
Winners and Losers		
Change in Benefit over Current Level	Percentage of Michigan School Employees	
	Option 2	Option 3
Decrease in benefits of more than 10%	0.3%	0.1%
Decrease of 5% to 10%	8.3%	7.2%
Decrease of less than 5%	0.8%	1.2%
No Change	44.2%	17.6%
Increase of less than 5%	44.4%	45.5%
Increase of 5% to 10%	1.5%	27.9%
Increase of more than 10%	0.5%	0.5%
Total	100.0%	100.0%

School districts will pay an average of \$11,362 for health insurance per employee in FY2005/06. The average cost varies by plan type from \$12,349 for fee-for-service coverage to \$9,075 for HMO plans. We estimate that the cost per employee would be \$9,889 or a savings of \$1,473 per employee if all school districts were participating in a state-wide health plan as outlined in Option 3. This option provides school districts and their employees with a choice of two PPO plans, as well as a POS plan and all of the existing HMO plans.

To arrive at our recommendations, we gathered and analyzed detailed health plan information from 244 school districts. We found that, with relatively few exceptions, the school employees' health plans have broadly equivalent benefit levels. Where there were observable differences, the current array of plan designs could map into one of two benefit levels for each type of plan (e.g. a Basic PPO plan and an Enhanced PPO plan) with little or no impact on plan benefits or design. These findings are presented in Section IV.

Survey Findings

The survey response rate was greater than we expected based on our experience with similar surveys. Quality data was received from 29 percent of the 835 school districts covering 43 percent of the total school employee population.

The largest enrollment was in FFS plans, followed by PPO plans and HMOs. Table ES.3 shows the distribution of school district employees' enrollment by plan type and compares it with information from our 2004 Hay Benefits Report survey on the prevalence nationally of the various plan types among employer-sponsored health benefit plans.¹ We have also shown the data from just the governmental employers included in the Hay Benefits Report, as governmental plans have been historically different than private-sector plans. Table ES.3 shows that the most common plan type for Michigan school employees are Fee-for-Service plans, whereas both nationally and among governmental employers the most prevalent plan type is the PPO.

TABLE ES.3			
Prevalent Plan Type			
Type of Medical Plan	Hay Benefits Report		
	Michigan School District Employees	Governmental Employers	All Employers
Fee-for-Service	48 %	8 %	2 %
PPO	30 %	54 %	61%
HMO	14 %	32 %	25 %
POS	8 %	6 %	12%

State-wide Plans

We examined two state-wide plans in Michigan. These are the plan provided to retired school employees through the Michigan Public School Employees Retirement System (MPERS), and the benefits provided to state employees through the Michigan Department of Civil Service (Civil Service).

We also surveyed the health plans of school employees in 15 other states for this report. These include the states close to Michigan as well as others that are of particular interest. Delaware and South Carolina provide mandatory health insurance for all school district employees through a state-wide health plan; Texas requires participation of small school districts in a state-wide plan, and ten states (including Texas for large school districts) permit school districts to voluntarily participate in the state health plan for state employees. The remaining three states surveyed do not permit school districts to participate in state-wide plans. Section III provides details of these arrangements, including the type of health care plans, coverage, and governance of the plans.

¹ Over 1,000 employers participate in the Hay Benefits Report including public and private employers of all sizes and across all regions. A copy of the 2004 Hay Benefits Report was provided to The Michigan Legislative Council.

Approach for Implementing a State-wide Health System

Section VI discusses the implementation issues and sets out an outline of the timeframe and the tasks needed for implementation. Based on our discussions with the various groups that currently administer health benefits for school employees, we recommend that the state-wide system be administered by either MPSERS or a new state agency. With appropriate additional funding we believe that the MPSERS operations could be expanded to cover school district employees as well as retirees.

Another alternative would be to establish a new state agency. The primary advantage would be that the new agency would focus directly on the health care for employees rather than retirees. The primary disadvantage is that establishing an entirely new organization would delay implementation of the state-wide system by at least a year.

Even with adding the employees to MPSERS it would take some time to establish a statewide plan, and school districts should only be required to join after their current collective bargaining agreements expire. Absent extraordinary legislative action, we believe that July 2006 would be the earliest practicable effective date for a statewide health plan for School District employees. Section VI sets out the time line for implementation of a state-wide system.

Depending on the design of the system, we project first year savings of \$57 million to \$193 million in the school district fiscal year 2006-07 (assuming a July 1, 2006 implementation date and an initial start-up investment of \$1.5 million) with savings rising to \$215 million to \$422 million by fiscal year 2009-10 when all of the current bargaining agreements would have expired. These eventual savings are much higher than the \$145 million to \$281 million that would have been saved in FY 2005-06 because of anticipated health care inflation.

If Michigan were to implement option 1 on a mandatory basis for FY 2006-07, we estimate that the first year savings would be approximately \$57 million, rising to \$215 million in FY 2009-10 (Table ES.4). If Michigan were to implement option 2 on a mandatory basis for FY 2006-07, we estimate that the first year savings would be approximately \$67 million, rising to \$230 million in FY 2009-10 (Table ES.4). The negative savings for FY 2005-06 represent initial program start-up costs.

TABLE ES.4			
Mandatory Plan starting July 2006			
(School Fiscal Year 2006/07)			
	Option 1	Option 2	Option 3
Year	Total Savings	Total Savings	Total Savings
2005/06	(\$1,500,000)	(\$1,500,000)	(\$1,500,000)
2006/07	\$57,109,113	\$66,882,947	\$192,533,841
2007/08	\$165,046,755	\$178,388,189	\$349,903,597
2008/09	\$203,244,589	\$217,461,777	\$400,235,737
2009/10	\$215,267,774	\$230,195,822	\$422,108,480

If Michigan were to implement option 3 on a mandatory basis for FY 2006-07, we estimate that the first year savings would be approximately \$193 million, rising to \$422 million in FY 2009-10 (Table ES.4). If the implementation were delayed until the 2007-08 fiscal year, the savings would be delayed, but would reach the same ultimate level by 2009 (Table ES.5). If Michigan were to implement Option 3 on a voluntary basis for FY 2006-07 (see section V.C for a discussion of voluntary versus mandatory participation), we estimate that the first year savings would be approximately \$115 million, rising to \$350 million in FY 2009-10 (Table ES.5). Again, if the implementation were delayed until the 2007-08 fiscal year, the savings would be delayed, but would reach the same ultimate level by FY 2009-10 (Table ES.5).

Table ES.5			
Option 3			
	Voluntary Plan starting July 2006 (School FY 06/07)	Mandatory Plan starting July 2007 (School FY 07/08)	Voluntary Plan starting July 2007 (School FY 07/08)
Year	Total Savings	Total Savings	Total Savings
2005/06	(\$1,500,000)		
2006/07	\$115,266,766	(\$1,530,000)	(\$1,530,000)
2007/08	\$236,246,539	\$263,375,610	\$184,185,708
2008/09	\$316,621,109	\$398,894,387	\$315,279,759
2009/10	\$349,863,252	\$422,108,480	\$349,863,252

Recommendation

Key elements of our recommendation are:

- A choice for each school district from among three types of health plan delivery systems: Either a Basic or Enhanced PPO plan, as well as a POS plan and all HMOs currently available to school district employees.
- The system should be mandatory, at least for the smaller school districts, but would not require participation by school districts until their current collective bargaining agreements expire.
- The school employees' plan would be administered by MPSERS but with a different set of benefits than for retired school employees.
- School districts and employee unions would decide how to allocate additional savings, or costs, between the school districts and their employees through collective bargaining in the school district.
- School districts would determine which employees would be eligible for the benefits.
- The state-wide plan would provide dental and vision benefits on a voluntary basis. School districts could purchase dental and vision benefits outside the state-wide system.

Section VII describes the reasons for the recommended approach for a state-wide health system for school employees and estimates the projected savings over the next four years.

II. CURRENT SYSTEM

A. Overview

There are approximately 835 school employers in the State of Michigan, including public school districts (over 550), intermediate school districts (57), charter schools (approximately 200) and community colleges (28). The term "school district" as used in this report refers to all four types of school employers. Approximately 190,000 school district employees are covered by health insurance.

We developed a Health Care Benefits Survey, a copy of which is provided in Appendix B, to study the current health benefits provided to school district employees. The survey was distributed to the public school districts with the assistance of the Michigan School Business Officials and the Michigan Association of School Administrators; to charter schools with the assistance of the Michigan Association of Public School Academies; and to community colleges with the assistance of the Michigan Community Colleges Association. We received responses from 244 school districts. A list of school districts with names that could be determined from the responses is included as Appendix A. Some of the responses did not have a school district name included.

The survey collected data on the range of cash incentives or other credits paid to employees who waived health coverage. Over 80 percent of school districts provide a cash incentive for employees who waive coverage. Of those schools that provided a cash incentive for waiving coverage, some provided a fixed dollar amount. However the most common approach was to pay the single premium amount for employees who waived coverage (single or family), with a few schools paying a portion of the premium (e.g. 50 percent or 85 percent). We found that a relatively small number of school districts provided cash payments only to employees who waived family coverage. The average cash payment in lieu of coverage was \$3,015.

In developing our model, we assumed there would be no change in the incentives for waiving health coverage offered to employees by school districts. Thus, these incentive costs are not included in the development of the aggregate cost for a state-wide health plan, nor are they factored into the cost savings projected for options 1, 2 or 3.

Each survey respondent was asked to identify the plan with the largest enrollment and provide details on that plan's administration and financing. For self-funded plans we collected data on individual and aggregate stop-loss coverage levels and premium rates.

The survey collected information on two benefits that are often carved out and separately managed: prescription drug benefits, and mental health and substance abuse treatment.

We also collected information about case management activities, including large case management, psychiatric care management and disease management.

Table 2.1 shows the enrollment and annual premiums reported by the survey respondents listed in Appendix B by purchasing mechanism.

TABLE 2.1		
Results of School District Survey by Purchasing Mechanism		
	Enrollment	FY2005/06 Annual Premium
MEBS	756	\$7,343,000
MESSA Choices 1	7,904	96,057,000
MESSA Choices 2	6,076	72,506,000
MESSA Super Care 1	22,924	298,156,000
MESSA Trimed	2,549	26,672,000
SET SEG	1,097	11,739,000
Blue Cross Blue Shield	20,722	216,115,000
HAP	7,436	68,028,000
Blue Care Network	3,411	32,842,000
Miscellaneous	5,480	60,112,000
Community Colleges	3,623	37,602,000
Grand Total	81,978	\$927,172,000

The survey results in Table 2.1 were grown by plan specific factors to develop the total costs, shown in Table 2.2. In developing the final costs we grew the enrollment and the costs by the same factor. The factor was assumed to be the ratio of the total expected in the plan type as depicted in the various sources of data to the total respondents of the plan type from the survey.

Where available, we increased the total number in the survey in a type of plan by the number reported by other sources. For instance, we increased the number reported as having Blue Cross Blue Shield by multiplying by a factor of 1.80, which is the total 37,299 enrollment reported to us by BCBSM divided by the 20,722 enrollment reported by all respondents to our survey.

The enrollment reference used in the development of the factors came from the following sources:

- MESSA filing to estimate the enrollment in various MESSA Plans
- Blue Cross Blue Shield report to estimate the total population covered by BCBSM
- SET SEG report to estimate the enrollment in SET SEG plans
- CEPI data was used to estimate the total school enrollment
- Data provided by other interviewees

CEPI (Center for Education Performance and Information) data gives us an estimate of the total school population including the part time employees. This data was used as the master data in coming up with factors to increase the surveyed population to the CEPI estimated population, thereby coming up with the estimated healthcare expenditure.

In most cases, the number of covered employees reported by the school districts was less than the total employment reported by CEPI. We understand that that occurs because not all

employees in a school district are eligible for, or participate in, the health plans. The average number of covered employees reported by the school districts was 77 percent of the total reported by CEPI. We assumed that the same proportion would participate in health plans that did not respond to the survey.

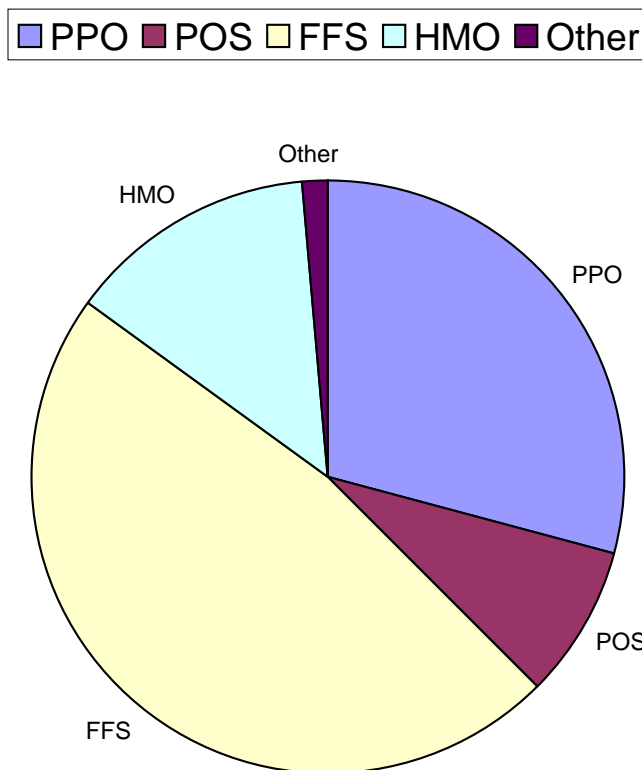
TABLE 2.2		
Total Expected Healthcare Expenditure		
	Enrollment	FY2005/06 Annual Premium
MEBS	1,989	\$19,312,000
MESSA Choices 1	10,970	133,305,000
MESSA Choices 2	16,538	197,352,000
MESSA Super Care 1	62,036	806,870,000
MESSA Trimed	6,302	65,942,000
SET SEG	2,698	28,878,000
Blue Cross Blue Shield	37,299	389,007,000
HAP	20,003	182,995,000
Blue Care Network	9,176	88,346,000
Miscellaneous	14,742	161,701,000
Community Colleges	8,756	90,871,000
Grand Total	190,509	\$2,164,580,000

Health benefits for most school employees are collectively bargained as part of a total compensation package. From the employees' point of view, they represent a significant part of the total compensation package. From a budgetary point of view, they represent a significant part of overall personnel costs. Several employee representatives stated that it was their belief that, over the years, unions have accepted smaller salary increases in return for higher health benefits or greater employer contributions.

School districts provide health benefits to their employees through either insured or self-funded arrangements. The dominant provider of health care programs to school districts is Blue Cross Blue Shield of Michigan (BCBSM) either through direct contracts with school districts or through one of several health purchasing programs. We found that BCBSM provides over 80 percent of the health care coverage for school employees.

Traditional FFS plans are the predominant type of coverage for Michigan school employees, with PPO plans being the second most common form of coverage. Fourteen percent are covered through HMOs. Chart 2.1 shows the distribution of Michigan school employees by type of health care coverage.

Chart 2.1
Source of Health Care Coverage

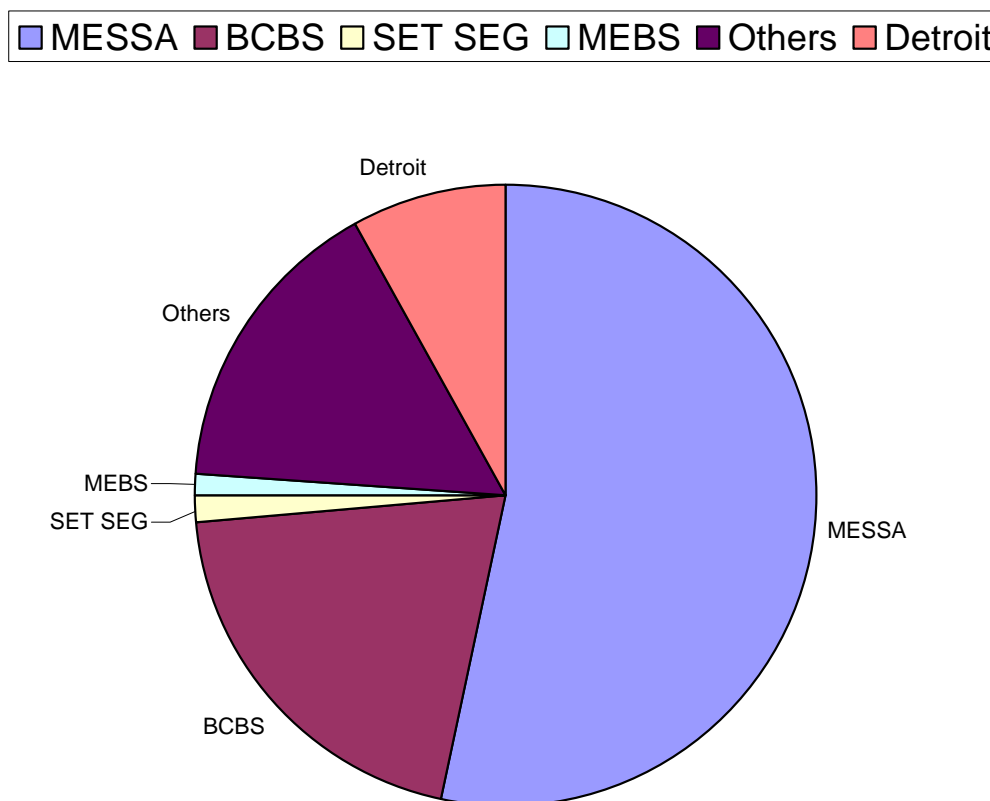


B. Group Purchasing Mechanisms

Michigan school districts have a number of mechanisms through which they can purchase health care coverage. By purchasing "mechanisms" we mean that school districts may obtain health care coverage through a group-purchasing arrangement designed to reduce health care costs by leveraging economies of scale. In this section we examine four of the largest group health care purchasing arrangements, the largest of which is the Michigan Education Special Services Association (MESSA). As HMOs are a type of group purchasing mechanism, we summarize here those available to school districts. Finally, in this section we describe the purchasing arrangements of the Detroit Public School System, which is large enough to achieve economies of scale and significant savings on its own.

Chart 2.2 shows the distribution of the number of school employees covered by each type of purchasing mechanism.

Chart 2.2
Distribution of Number of School Employees by each type of Purchasing Mechanism



Michigan Education Special Services Association (MESSA)

Three fourths of school districts, with 53 percent of all school district employees, obtain their health insurance through MESSA. MESSA contracts for health insurance through BCBSM. The average school district health benefit enrollment for MESSA is 214 employees compared to 288 employees for all school districts.

MESSA was established more than 40 years ago by the Michigan Education Association (MEA). MESSA is structured as a separate tax-exempt legal entity called a voluntary employees' beneficiary association (VEBA).² The MEA established the MESSA to provide employee welfare benefits (other than pensions) through school district (and employee) contributions.

² See section 501(c)(9) of the Internal Revenue Code.

MESSA offers insurance to any district with at least one MEA bargaining unit. As part of its services to school district employees MESSA self-administers certain related services.³

Despite the fact that MEA represents the vast majority of school employees, MESSA programs cover only 58 percent of all MEA members and 55 percent of all school employees. Approximately 24 percent of the school district employees are not represented by the MEA. These statistics indicate that MESSA is viewed as an attractive mechanism for purchasing health insurance, independent of its affiliation with the majority union for school district employees.

The programs offered by MESSA are designed to provide a stable source of coverage to smaller districts; larger districts are assumed to be less reliant on MESSA for health care coverage.

MESSA medical and prescription drug coverage is fully insured through BCBSM.⁴ Premium rates are developed by region.⁵ Rates for alternative packages are determined by a rate-book method (*e.g.*, a \$100 deductible in a region is a standard factor times a \$200 deductible plan). MESSA does not rate by age for medical coverage. Dental benefits are provided on a fully-insured basis through Delta Dental.

MESSA coverage has grown significantly over the last decade and a half – from 80,000 covered lives in 1990 to 98,000 today. MESSA staff attributes this growth to providing a good price/quality balance. Most of the current growth is occurring among non-MEA groups, particularly administrator groups.

MESSA internally provides much of the administration associated with its programs, including the following services and programs:

- In-house nurses
- In-house medical director
- Diabetes management program
- Enrollment & billing
- Customer service
- Integration of medical & disability
- Disability claim adjudication
- Non-participating provider claims
- Large claim case management
- Cardiovascular, asthma, youth health programs
- Partnership with Mayo Clinic for health risk assessment

³ MESSA has a license to serve as a third party administrator (TPA).

⁴ MESSA has not always used BCBSM. They initially offered coverage through Mutual Benefit of NJ, then used Equitable, and moved to BCBSM in 1985.

⁵ The MESSA definition of region differs from the definition used by BCBSM.

- Wellness coordinator & wellness conference
- Coordination of benefits

The primary MESSA health care offerings are traditional FFS plans and PPOs, though the FFS enrollees outnumber the PPO enrollees. Most enrollees are in Supercare, which is the traditional FFS program. Enrollment in MESSA's PPO program is growing rapidly. A small and declining portion of eligible employees enroll in the POS program. MESSA offers POS coverage in eight counties; the rest of their products are available state-wide. MESSA does not offer any HMO plans.

MESSA offers school districts discounts on combinations of coverages, which may include medical, dental, vision and life insurance. Although all MESSA programs are insured, which limits their ability to tailor benefits for particular school districts, MESSA staff believe they have enough benefit options available through the existing products to provide a wide array of benefit choices for school districts.

With respect to its prescription drug program, MESSA has considered using a pharmacy benefit manager (PBM) for prescription drug coverage, but has decided not to do so for the time being. (PBMs are generally perceived as helpful in reducing prescription drug costs and improving monitoring of prescription drug utilization.) MESSA is, however, moving from a \$5/\$10 generic/brand co-payment plan to a \$10/\$20 co-payment plan, and is adding the requirement that the beneficiary pay the difference between the brand-name and generic price if a brand-name drug is purchased when a medically acceptable generic equivalent is available.

Michigan Employee Benefit Services, Inc. (MEBS)

The system commonly known as “MEBS” consists of three associated entities. The Michigan State AFL-CIO Public Employees Trust (PET) is a voluntary employees’ beneficiary association (VEBA) established by AFL-CIO member unions. Under its rules, PET may only provide benefits to public sector affiliates of the AFL-CIO.⁶ The Michigan Employee Benefit Services, Inc. (MEBS) administers the PET health benefit plans and provides administrative services to other employers.⁷ The Associated Mutual Hospital Service of Michigan, a Michigan licensed insurance company provides insurance to PET members and other MEBS customers.

The MEBS 3-Star LA insured plan uses the BCBSM high-deductible plan in order to access the Blue Cross Blue Shield network. Under this plan, a school district buys a fully-insured BCBSM high-deductible plan and MEBS provides a wrap-around plan that supplements the BCBSM policy to provide a comprehensive benefit package. Since MEBS “has access” to the BCBSM claim system only one claim submission is made to BCBSM. BCBSM adjudicates the high-

⁶ PET is primarily used by four unions: MFT, SEIU, AFSCME, and International Union of Operating Engineers (IUOE).

⁷ MEBS owns “Benefit Plan Administrators,” a pension administration company that also handles health reimbursement account (HRA) administration. MEBS has partnered with Huntington Bank as a trustee for the health savings accounts (HSAs).

deductible benefit, re-pricing the claim using its network discounts. MEBS then adjudicates the wrap-around benefit using the BCBSM negotiated fees.

In addition to its fully-insured arrangements, MEBS offers funding through minimum premium arrangements and self-funded arrangements. MEBS staff see their marketing strength as sharing with school districts experience data on “where they’re hurting,” and using it to help them manage their plan designs to control costs.⁸

PET is a member of the AFL-CIO Employee Purchasing Coalition (AEPC); this provides access to AEPC-negotiated prescription, vision, and dental coverage. The pharmacy benefits are managed by Caremark, a large pharmacy benefit management firm. MEBS staff describes Caremark as doing a “great job working with doctors and members on the use of mail-order” prescription services.

MEBS integrates health risk assessments into all its plans, using a web-based assessment mechanism (PKC Coupler). MEBS also makes extensive use of “passive” PPOs, because many of the groups coming to them from other programs were not in a PPO.

School Employers Trust and School Employers Group (SET SEG)

The Michigan Association of School Boards (MASB) established the School Employers Trust (SET) in 1971 and the School Employers Group (SEG) in 1973. SET provides members of MASB with a mechanism for group purchasing of health benefits. SEG offers non-health insurance coverage including workers’ compensation, property and casualty, errors and omissions, and boilers insurance.

SET offers a variety of medical benefit plans, which are insured by BCBSM. They currently provide some benefits that are not bundled with medical insurance, such as dental insurance, to approximately 11,000 employees but most of these do not have medical coverage through SET. Benefits available through SET include medical, pharmacy dental, vision, life, disability and travel.

School districts may purchase through SET any health plan offered by BCBSM. The most popular SET program has for in-network services no patient cost sharing; and for out-of-network services benefits are subject to a \$250 deductible and 80 percent coinsurance. School districts with fewer than 100 employees are fully insured on a pooled-rate basis. Districts with more than 100 employees are either self-insured or experience-rated. Benefits and rates are set by BCBSM.

Under the SET program, supplemental options can be added and are insured by Associated Mutual Hospital Service of Michigan (a small local insurer). These represent about one percent

⁸ MEBS provides experience reports to minimum premium and self-funded customers. Detailed claim experience is not provided to fully insured customers with fewer than 100 employees, but all customers with 100 or more employees receive experience reports. MEBS experience reports include experience for both the BCBSM-insured portion of the plan and the MEBS-administered portion of the plan.

of the total cost. Dental and vision benefits are offered through Fortis.⁹ SET is expanding its product offerings to include POS and HMO options, more self-funded options and a variety of co-pay schedules. They are also expanding their medical options to include high-deductible plans coupled with HSAs.

AFL-CIO Employee Purchasing Coalition (AEPC)

AEPC is a joint labor/management purchasing coalition, established in 1993 to assist organized labor in the group purchasing of health care services. It negotiates preferred prices for self-funded prescription drugs, dental and vision benefits. AEPC is a collective purchasing mechanism rather than an insurance program or risk-spreading mechanism. All AEPC members have unionized workers.¹⁰ AEPC only offers self-funded programs, with the exception of dental where both self-funded and fully insured programs are available through Delta Dental.

Historically, prescription drug purchasing has been the major focus for AEPC. AEPC currently has over 200,000 covered lives in its prescription drug program. It has negotiated contracts with Delta Dental and with ADN for third-party administrators (TPAs) that want to lease a dental network. AEPC believes there is a need for more quality improvement and cost control in the Michigan market.

AEPC staff believe that prescription drug programs do not coordinate closely enough with medical care services, particularly in the area of chronic/disease management. According to AEPC, most TPAs provide bundled case management and hospital review programs, but most do nothing on chronic care/disease management. Local carriers bundle chronic care/disease management with their administrative fees, but do not generally do it as well as other “best in breed” health plans in other US markets. Some local carriers are challenged with doing effective chronic care/disease management for AEPC because of the carve-out prescription drug benefit. Effective chronic care/disease management depends on the integration of prescription drug data with medical claims data. Some local carriers either will not accept the drug data from AEPC’s pharmacy vendor or charge a prohibitive fee for doing so.

Detroit Public Schools System

The Detroit Public Schools (DPS) provides a useful look at how a large school district deals with its health care costs. DPS is the largest school district in Michigan. The great majority of the system’s employees (96 percent) are unionized. There are 16 unions, and over 20 separate bargaining units. Salaries and benefits represent approximately 85 percent of the district’s total costs.

DPS currently has over 15,000 employees enrolled in medical coverage (not all employees are eligible and some choose not to participate). DPS faces significant financial and other

⁹ MESSA has an exclusive arrangement with Delta to offer dental in MEA districts. Delta does not compete with MESSA by directly marketing dental benefits to MEA districts.

¹⁰ The Public Employees Trust (PET), administered by MEBS, is a member of AEPC.

challenges. The system is facing a budget deficit of about \$250 million dollars, and declining student enrollment. The district has already experienced some significant downsizing, and could lose another 5,000 employees in the next three years. Detroit's population is declining at a rate equivalent to approximately 39 families leaving the city each day.

DPS faces significant financial challenges in the years ahead. Some school buildings have less than 50% occupancy due to declining and shifting populations (though some neighborhoods are growing, requiring the district to build schools in some areas while closing existing schools in other areas). DPS constructed and opened 16 new schools in the past three years. Other factors bearing on DPS' financial condition are: the average age of buildings is 63 years; DPS has high maintenance costs; new school buildings are needed; but, under its Deficit Reduction Plan DPS expects to close 100 buildings over the next five years.

Historically, health care and other fringe benefits have been a critical recruiting tool for DPS. In the 1950's, 60's and early 70's benefits were used as a means of competing with the auto companies for employees, because the school system had much lower salaries. With recent economic changes, school salaries are now competitive, and the system has become a very attractive place to work. The average age of school employees is 56, and the average tenure is 15 years. As a result, the district has a "large number of retirement age participants in an active plan."

DPS currently offers four BCBSM health plans:

- A self-funded traditional FFS plan that insures 32 percent of enrollees
- PPO (the older PPO network)
- "Community Blue" PPO (the newer PPO network)
- Blue Care Network HMO

DPS offers employees four HMOs. In addition to the Blue Care Network HMO, these include: Health Alliance Plan (HAP), Wellness Plan, and Total Health Care Plan. The majority of the system's HMO enrollment is in the Blue Care Network HMO and in HAP. New hires are required to spend their first two years in one of the HMO plans; after that, although they can change plans, they tend to stay in the HMO plans.

DPS has carved out the prescription drug benefit across the board, for all plans. This was done two years ago. The drug benefits are self-funded and administered through Caremark. DPS see three distinct benefits from carving out the pharmacy benefit. First, this change saved about \$3.5 million, before making any plan design changes. Second, it has allowed the district to hold the increase in drug costs to less than three percent a year over the last two years. Third, in addition to the cost savings, Caremark has established a database on drug usage and disease state that is intended to support wellness and disease management initiatives. DPS staff believes that avoiding double digit increases in prescription drug costs is a significant victory in the effort to control the cost of health benefits.

DPS offers three dental options, all of which are provided through Delta Dental:

- Traditional FFS plan (self-funded)
- Dental PPO (self-funded)
- DMS (insured)

Vision benefits are provided through Co/op Optical, a non-profit cooperative.

DPS purchases health benefits directly, and is not part of a group purchasing arrangement such as MESSA. The district has a unique advantage because of its size, and benefits from that advantage. DPS staff indicated that the district is large enough to do what it needs to do without working through an intermediate purchasing organization. DPS has used self-funding since the 1960's. To facilitate contracting with the best health care arrangements, the district no longer names specific health insurers or HMOs in its union contracts.

DPS places a strong emphasis on the need for cost and utilization data. Without good data, it is impossible for a district to know if it is getting a good deal, and whether disease management or wellness initiatives are needed. One reason DPS chose to carve out the prescription drug benefit was to get disease-state information. It has been getting much improved information as health plans improve their systems and reports.

The district is a leading customer for most of its suppliers and vendors. The resulting leverage and the broader enrollment base give DPS a strong position to negotiate rates and terms with health care providers. At the same time, the district is working to become a better client in order to improve further its bargaining position. In the past, DPS had four internal computer systems involved in enrollment and billing, leading to late payments and administrative errors. On a monthly basis, several hundred enrollments would be incorrect due to paperwork lags. People would be dropped from the enrollment files for no apparent reason. To address this, they outsourced their enrollment and eligibility process.

Ceridian is performing DPS' enrollment, and is also responsible for providing customer support. For the customer support, Ceridian is judged based on resolution rates. The enrollment/eligibility process is now 100% electronic, using web-based self-enrollment. DPS staff reports they are achieving 98% enrollment accuracy on a monthly basis (the 2% are attributable to user errors). They are now paying vendors on the basis of their enrollment data, greatly reducing late payments. DPS staff estimated that outsourcing this process has saved approximately \$3.5 million.¹¹

¹¹ To illustrate the cost of late payments, one DPS health care provider had built a \$300,000 late payment fee into its premium rates.

Michigan Health Maintenance Organizations (HMOs)

Unlike the Michigan Civil Service Plan where 40 percent of the employees participate in HMOs, according to our survey only 14 percent of school district employees elect to participate in an HMO. Most school district employees participate in traditional fee-for-service plans or PPOs. DPS is a notable exception to this general rule, because, as noted above, DPS requires that all new teachers must spend the first two years of health care coverage in an HMO.

There are 12 HMO's with commercial populations over 3,000 operating in Michigan. They are:

- Aetna Health, Inc –Michigan
- Blue Care Network of Michigan
- Care Choices HMO
- Grand Valley Health Plan, Inc.
- Health Alliance Plan of Michigan
- HealthPlus of Michigan, Inc.
- M-CARE, Inc.
- Priority Health
- Physicians Health Plan of Mid-Michigan
- Physicians Health of South Michigan
- Physicians Health Plan of Southwest Michigan, Inc.
- Total Health Care, Inc.

The five Michigan HMOs with the largest enrollments are summarized in table 2.3. Additional information on the Michigan HMO market may be found in Appendix D.

TABLE 2.3	
Largest Michigan HMO Enrollments	
Blue Care	457,000
Health Alliance of Michigan	380,000
Priority Health	367,000
M-CARE	176,000
Care Choices	103,000

C. Results of the School District Survey

Table 2.4 shows the number of school districts that participated in our health care survey, and the number of employees they cover, compared to the estimated total universe of Michigan school districts and employees as reported by Center for Education Performance and Information (CEPI). We received surveys for 30 percent of the school districts representing 43 percent of the employees covered by health plans. The survey responses included Detroit, so we have 60 percent of the covered population for districts with over 1,000 employees. The lowest response rate was for the smaller school districts. However, the global information provided by MESSA included the majority of these school districts. For these and other reasons we believe we have gathered sufficient information to draw reasonable conclusions about the current costs for school district health care and to derive reasonable cost-savings projections.

TABLE 2.4						
Survey Results Compared to Control Totals						
	Number of School Districts			Employees in Health Plans		
Number of Employees in District	Survey	CEPI Data	% of Total	Survey	CEPI Data	% of Total
<100	87	387	22%	4,333	16,010	27%
100-1000	145	412	35%	40,720	110,446	37%
>1000	12	26	46%	33,302	55,218	60%
Total	244	825	30%	78,355	181,674	43%

Table 2.5 shows (in ascending value) the relative benefit values for the most prevalent plans, not including HMOs. We determined the relative benefit values using the Hay Benefit Value Comparison (BVC) method. The BVC enables us to compare the relative value of the benefits package by controlling for differences in plans, such as demographics and funding methods that distort the direct comparison of premiums. The BVC values shown in Table 2.5 represent program costs, which include the value of benefits provided and the savings produced by using a negotiated provider network. Consequently, the BVC value of a PPO or POS plan will be lower than a FFS plan with exactly the same benefits. Thus, because of network discounts, moving from a FFS plan to a PPO plan will often result in both lower costs and reduced patient cost sharing. If network savings were ignored, and BVC values were calculated reflecting only differences in the benefit provisions, the MESSA Tri-Med and MESSA Choices plans produce the highest values. The BVC method is explained in detail in Appendix C.

TABLE 2.5		
Results of Benefit Value Modeling		
Name of Plan	Type Of plan	BVC Value
Blue Choice POS	POS	4,357
Ultra Med Preferred 1	PPO	4,896
Community Blue PPO	PPO	5,176
MESSA Choices II	PPO	5,191
Blue Managed Traditional	FFS	5,247
MESSA Choices (see note below)	PPO	5,258
MESSA Tri-Med (see note below)	PPO	5,329
MEBS	FFS	5,515
MESSA Super Care I (average value based on the four levels of coverage)	FFS	5,800
Weighted Average Value		5,443

As a basis for designing a state-wide system we considered the range of plans available. The BVC value shown in table 2.5 for MESSA Super Care I (5,800) is the average of four different levels of coverage available with Super Care I. Table 2.5A shows the four MESSA Super Care I plans and their BVC values. The \$50 deductible MESSA Super Care I, a FFS plan, had the highest value, at 5,918 (*i.e.*, the richest plan of benefits), or approximately 109 percent of the overall average for Michigan schools.

TABLE 2.5A		
Results of Benefit Value Modeling for MESSA Super Care I Plans		
Deductible (Single / Family)	Prescription Drug Copay	BVC Value
\$50 / \$100	\$2	5,918
\$100 / \$200	\$2	5,805
\$50 / \$100	\$5 / \$10	5,794
\$100 / \$200	\$5 / \$10	5,684
Average for Super Care I		5,800

The Blue Choice POS had the lowest value (*i.e.*, the least rich plan of benefits), at 4,347, or approximately 80 percent of the overall plan average. The BVC values for PPO and POS plans are weighted values based on the in-network and out-of-network plan provisions. When we compare the values of the PPOs we see they fall into a relatively narrow range of values (*i.e.*, 4,896 to 5,329), hence indicating that the most prevalent PPOs offer benefits of similar value.

Table 2.6 shows the plan details of the most valuable FFS plan (MESSA Super Care I), the most valuable PPO (MESSA Tri-Med PPO, using the average option offered under that plan), and the least valuable POS (Blue Choice POS). Evident from Table 2.6 is that the high value, and hence high cost, of the MESSA Super Care I plan is the patient's ability to use any doctor or care provider. Beyond that, the benefit designs among the MESSA Super Care I, and the in-network provisions of the PPO and POS are not radically different.

Comparison to Health Plans Nationwide

The 2004 Hay Benefits Report contains information on the employee benefit programs provided by over 1,000 employers throughout the United States. These employers represent all major industrial sectors and geographic regions. We have computed the benefit value of the health plans sponsored by the employers participating in the 2004 Hay Benefits Report, and compared the overall values to the values calculated for the most prevalent plans above. All but one of the health plans in Table 2.6 are valued higher than the 90th percentile in the Hay Benefits Report database. In other words all of the Michigan school employee health benefit plans, with the exception of Blue Choice POS, are more valuable than 90 percent of the health care plans in the 2004 Hay Benefits Report. Half of all employer-sponsored health benefit plans in the Hay Benefits Report have a BVC value less than 4,414

TABLE 2.6					
	High Option MESSA Super Care 1	Average Option MESSA Tri-Med PPO		Low option Blue Choice POS	
Type of Care		In-network	Out-of-network	In-network	Out-of-network
Plan Deductible	\$50 - \$100	\$0	\$0	\$0	\$100
Maximum Out-of-Pocket Limit	\$1,000	\$0	\$1,000	\$0	\$1,000
	Co payments/Coinsurance				
Inpatient hospital	100%	100%	90%	100%	80% after deductible
Surgical	100%	100%	90%	100%	80%
Physician Visits	90%	\$5 co-pay	90%	\$20 co pay	80% after deductible, and \$20 co pay
Specialty Visits	90%	\$5 co-pay	90%	\$20 co pay	80% after deductible, and \$20 co pay
Mental Health and Substance Abuse Treatment – Inpatient	100%	100%	50% up to 40 days	100% up to 45 days	80% after deductible, up to 45 days
Mental Health and Substance Abuse Treatment – Outpatient	90% up to 50 visits	\$5 co-pay	50% up to 30 visits	100%	80% after deductible
Preventive Services	100%	\$5 co-pay	90%	\$20 co-pay	Not Covered
	Prescription Drug Coverage				
Coverage for Generic	\$2 - \$5 co-pay	\$5 co-pay		\$10 co-pay	75% after \$10 co-pay
Coverage for Preferred	\$2 - \$5 co-pay	\$10 co-pay		\$15 co-pay	75% after \$15 co-pay
Coverage for Non-preferred	\$5 - \$10 co-pay	\$10 co-pay		\$20 co-pay	75% after \$20 co-pay
BVC Value	5,800	5,329		4,357	

Dental coverage is available under a separate plan that covers most procedures at 80 percent coinsurance. Vision care benefits are available under a separate plan that provides three levels of coverage. Vision care plan co-payments provide approximately 45 to 100 percent coverage. The BVC values above do not include dental or vision care coverage.

Comments from Interested Parties

We solicited input from interested parties through a series of interviews. In addition, we sent each group that we interviewed a preliminary outline of the design options included in the study and asked for their comments. While all of the groups we contacted were very generous with their time, and very open during the interview process, most declined to make any formal comment on the design options. Without identifying specific individuals or organizations, there are certain conclusions that may be drawn from this feedback.

First, many argue that Michigan already has a de facto state-wide system. MESSA provides group purchasing of health benefits to any school district with at least one MEA bargaining unit. MESSA clearly has sufficient enrollment to have already captured most of the savings that are available solely on the basis of size and bargaining power.

Second, many report that school districts find it difficult to obtain the experience data they need to actively manage their health benefit plans. This is particularly true for districts purchasing fully-insured coverage. One person we spoke with suggested that the state should require health plans to release, to those districts that request it, data on their own claims experience.

Some of the commentators emphasized that there was a need to maintain high quality health benefits protected from unilateral decisions from third parties. The major decisions on the level, cost-sharing and extent of coverage should remain with the local school districts and employees.

Third, there appears to be a related, broadly held concern that the current system places insufficient emphasis on disease management, health promotion and similar tools to improve the health of school employees and reduce the cost of providing health benefits. One person suggested that school health benefits should be viewed more as a means for reducing absences due to health problems, and less as an additional source of compensation. Another group suggested that the state could encourage this by providing a state-funded catastrophic reinsurance pool, and requiring schools to implement health risk assessments, large case management and disease management programs in order to participate.

Several groups we spoke with suggested that the one thing BCBSM does best is negotiate with providers. There seems to be general agreement that BCBSM has the best provider discounts in the state.

A major concern has been the sharp fluctuations in the premium increases that have been experienced by many school districts. Any change in the health benefits system should provide mechanisms for smoothing premium rate increases and controlling annual fluctuations.

Finally, many of the groups and individuals we spoke with expressed the concern that a state-wide system might be used to remove health benefits from the collective bargaining process, or to reduce costs by making arbitrary reductions in benefit levels. One of the groups stated that, in their opinion, past bargaining has resulted in higher than average health benefits in return for lower than average salary.

D. Plan Administration

The key drivers of a plan's costs are the level of the benefits, the cost or level of charges for the covered benefits (*i.e.*, how much hospitals, doctors, and other care providers are paid), the utilization of those benefits by plan members (*i.e.*, the frequency and intensity of illness, disease, injury, and visits to care providers), and the non-benefit costs that are required to administer the plan (*e.g.*, costs of claims processing). While plan design does influence utilization, once the plan of benefits is determined, the primary driver of the total plan cost is effective administration and management of the plan. Hence, one of the most controllable elements of health care costs are the administrative costs. Also effective plan administration is essential to providing benefits effectively and is critical for customer satisfaction.

To evaluate the effectiveness of plan administration we analyzed the administrative practices currently used by the largest providers of health care to school districts. In our recommendations and projected cost savings we quantify how much money could be saved if "best practices" in key administrative areas were used.

In order to gather information on current administrative practices and cost controls we sent questionnaires to, and interviewed, Michigan's major health care administrators, namely: BCBSM, MESSA, MPSERS, SET SEG, MASB, DPS, and the Michigan Civil Service Department. This section summarizes our findings in this area.

Eligibility Maintenance

BCBSM indicated that for their education customers, the enrollment process was largely dictated by the employer. Daily, weekly, and monthly eligibility update options are available; however, the use of their on-line Membership Collection System (MCS) for entering eligibility data was limited to employers with 50 or more employees, and tape transfers were generally available only for larger systems with 250 or more employees. Most employers with fewer than 50 covered lives used a paper enrollment/disenrollment process.

MESSA indicated that they use a monthly billing process to invoice school districts.

MPSERS indicated that they operate an eligibility maintenance system using daily updates.

SET SEG use a paper-based enrollment system, with open enrollment in the fall and changes in eligibility processed within two days from receipt of notification of change.

DPS recently outsourced their enrollment and eligibility system to Ceridian. This has greatly improved the enrollment process, allowing employees to self-enroll using a web-based system, which greatly improved the accuracy of the eligibility database. DPS now pays vendors on the Ceridian enrollment data greatly reducing late payment fees. DPS estimates that this process has saved approximately \$3.5 million a year.

Civil Service provides weekly updates of enrollment data to each of the plans and carriers.

Dependent Eligibility before College

Each MESSA customer (*i.e.*, school district) determines eligibility of dependents, based upon age and dependent information provided on the enrollment application.

MPERS requires copies of marriage and birth certificates to confirm eligibility.

SET SEG sends annual notices to school districts requesting them to confirm dependent eligibility.

Civil Service requires copies of marriage and birth certificates to confirm eligibility.

College Student Eligibility

BCBSM indicated that they use an annual confirmation process with the parent of the student, supplemented with a requirement for actual proof of attendance at college every three to five years.

MESSA requests college enrollment information annually.

MPERS has an annual dependent certification process which is performed for all dependents age 19 to 25. At age 25, dependent coverage is automatically terminated unless the disabled dependent eligibility requirements are met.

Civil Service requires documentation of college attendance from the college to confirm eligibility for dependents over age 19.

SET SEG administratively covers dependent children until December in the year they attain age 19.

Grace Period for Coverage after Termination

There was considerable variation in plan administration practice with respect to coverage after termination of employment or eligibility. BCBSM generally covered members until the cancellation was processed, with retroactive terminations of eligibility limited to 30 days, while MESSA had a 60 day grace period. Under MPERS, coverage is effective until the end of the month, and under Civil Service coverage continues to the end of the pay period, or date of divorce for spouses.

Coordination of Benefits (COB)

Virtually all of the school district health care plans include a coordination of benefits (COB) requirement. Under COB rules, where a patient's health care costs are covered by two or more programs, plan administrators must decide which program pays first, and which program pays any remaining unpaid balance. For example COB issues arise when, for example, both spouses have coverage for their respective employers or the employee incurred an on-the-job injury

covered by Workers' Compensation or a patient was injured in a car accident and car insurance will pay all or part of the medical costs. Effective monitoring and administration of COB is a critical to cost-savings.

School districts covered by BCBSM have three COB options. They can: choose a “pay and pursue” approach, or the more common (and more aggressive) “pursue and pay” approach, or a passive approach (pay at end of 45 days). Under the first approach, BCBSM first pays the benefit and then determines if there is a second party that should have paid part or all of the benefit. The second approach would make the determination first and then pay the remaining benefit. Across both education and other customers, BCBSM surveys enrollees about other health insurance coverage they may have every 14 months. This identifies many “Blue on Blue” situations, where the patient is covered by two different Blue Cross Blue Shield plans. BCBSM is creating new database to detect COB over all lines of business.

MESSA supplements the BCBSM Blue-on-Blue COB program by using its own staff to research potential COB claims. In cases where a claim indicates that an injury occurred at work, MESSA’s staff investigates potential recoveries from Workers’ Compensation. In third party and personal injury cases MESSA investigates and pursues recovery based on diagnosis codes.

For MPSERS, BCBSM uses an active “pursue and pay” approach to COB. When members are first enrolled, and annually thereafter, MPSERS uses a letter of inquiry to determine if other coverage is present. If claims are not reported correctly, they are rejected until processed by the primary payer. If other coverage information is received after a payment has been made, provider recoveries are pursued through information supplied by the member and on fields on the claim form. BCBSM also uses a vendor, Social Security Disability Consultants (SSDC), in concert with the Centers for Medicare and Medicaid Services (CMS), to determine when Medicare is the primary carrier for members under age 65. MPSERS also utilizes SSDC’s advocacy program for members that may qualify for Social Security benefits under age 65, and therefore be eligible for Medicare before attaining age 65. MPSERS reported that the return on investment for this effort was 9 to 1.

For MEBS and SET SEG, BCBSM manages the COB function.

For Civil Service, BCBSM manages the COB function, with a biennial canvas of employees to identify other sources of coverage.

Effective COB programs require effective information gathering, thorough research of the facts, aggressive follow-through on potential recoveries, and programs that pro-actively identify people who may qualify for other sources of benefits. Failure to use COB programs to their full potential can cost taxpayers and employees millions of dollars annually.

Large Case Management

As a significant portion of a health plan’s total expenditure is routinely incurred by a small portion of the membership, effective large case management is a major contributor to total health plan cost control. Effective large case management includes early identification of large cases,

periodic review of the patient's care and future needs, evaluation of alternative care options, and access to centers of excellence for transplants and other high-cost and high-risk procedures.

For school employees, other than those enrolled in HMOs, almost all care is provided by Blue Cross Blue Shield of Michigan's network of providers. BCBSM's large case management services are coordinated through BlueHealthConnection, which relies on multiple sources or mechanisms for identifying candidates for health coaching or case management services. To minimize missed opportunities and optimize timeliness and effectiveness of large case management, BCBSM employs a variety of mechanisms to identify the members with coachable needs. The identification of a case for intervention can be triggered by any of the following seven methods:

- Pre-certification/pre-notification. BCBSM nurses routinely ask questions in the telephone-based preauthorization process (used outside of Michigan) to help identify appropriate candidates. In Michigan, where they have an electronic pre-notification process, hospitals are able to flag candidates for case management intervention. BCBSM also has automated triggering mechanisms in their system as pre-notification and preauthorization data comes into their system.
- Call-based Case-finding. Significant opportunities to reach and engage members for effective intervention are often identified when a BlueHealthConnection health coach is on the phone with a member. On inbound and outbound calls, the health coaches will use "fishing" techniques to determine if the individual or any covered family member has a need for assistance with a health-related problem. Each interaction is used to build a relationship with the individual and a means for identifying opportunities.
- Internal Referrals. Recognizing that each member contact serves BCBSM as a possible source of referrals, BCBSM enlists Customer Service Representatives (CSRs) to be attentive to potential opportunities for case management. If a member reveals an unmet health need, the CSR will ask the individual if he or she is aware of, or interested in, BlueHealthConnection services. The CSR is able to initiate a referral to BlueHealthConnection for a callback by a health coach if the member so wishes.
- External Referrals. Health care providers, family members, and other sources can notify BCBSM of a member need.
- Data Mining/Predictive Modeling. BCBSM uses extensive analyses and mining of facility, professional and pharmaceutical claims data to identify cases that could benefit from BlueHealthConnection interventions. Methods used include: identifying cases with specific diagnoses, clinical events, high-cost claims, the application of sophisticated algorithms that detect and score gaps in care or patterns of use highly correlated with future health care utilization.
- Self-identification. BCBSM actively promotes that members should self-identify the need for BlueHealthConnection support, as it is a particularly timely, efficient and productive method for achieving effective member engagement. When BlueHealthConnection health

coaches call members, a considerable amount of time and effort is expended in explaining the program and assessing the value of engaging the member based on receptivity, readiness to change, and other similar factors.

- **Case Management.** Case management is the highest intensity level of care intervention in the BlueHealthConnection integrated program. The case management component is targeted to those members who are the sickest, highest risk or present the most complex cases in the acute or chronically ill population who need specialized, personal attention and support. Typically these are individuals who have experienced a catastrophic event or are dealing with a very serious or complex medical condition. In these types of cases the patient may not understand his or her condition or the complex treatment regimens he or she is expected to follow, or may have difficulty coordinating all the services needed for a positive outcome. Case management has proven its clinical and personal value many times over its costs.

Frequency of Review of Large Cases

For BCBSM, all large case management cases are reviewed weekly by medical consultants when BCBSM is primary, and monthly where BCBSM is the secondary payer. BCBSM manages this function for SET SEG.

For MESSA, each case is reviewed at least monthly for needs and continued, active coverage. Many cases are reviewed much more frequently from daily to weekly.

For MPSERS, BCBSM conducts bi-weekly follow-up, or more based on the condition of the patient.

Alternative Care Options

Alternative care options provide needed care in settings that may provide more appropriate care at lesser cost than hospitals. These options include long term acute care facilities, non-hospital residential physical rehabilitation facilities for medical conditions and residential facilities for substance abuse and mental health conditions.

With BCBSM, Case Managers are authorized to request exceptions to the plan design and go back to the plan sponsors with requests. Some school districts have given BCBSM *carte blanche* in determining alternative care options.

With MESSA, alternative care options to standard hospitalization benefits include: skilled nursing facilities; home health care and hospice; a wide range of out-patient benefits, including out-patient surgery, and physical and speech therapy for medical conditions; intensive out-patient programs for substance abuse treatment; out-patient substance abuse therapy; and partial hospitalization and out-patient psychotherapy for mental health conditions. Private duty nursing is also a provision of the plans, but only when the medical care requires the skill level of a licensed nurse under the supervision of a physician. All services must be medically necessary.

Under MPSERS, alternative care options are handled within the case management program structure; there is no standard versus special approval process.

Transplants

Transplant services are among the highest cost services, providing life-saving and life-extending care to a relatively few members. As most transplant care delivered to school employees is administered by BCBSM, there is great consistency in transplant treatment.

BCBSM's Quality Centers for Transplants are a cooperative effort among the BCBS Association, member Blue Cross and Blue Shield Plans and participating hospitals. This centrally coordinated national network of transplant institutions provides access to transplant services by combining quality and competitive pricing through nationally negotiated pricing arrangements. The program includes seven transplant types: heart, liver, single or bilateral lung, combined heart and bilateral lung, simultaneous pancreas and kidney, pancreas and autologous and allogenic bone marrow.

When performed at an approved facility MESSA members' pre-approved human organ transplant services are covered in full for heart, heart-lung(s), liver, lung(s), pancreas, partial liver, lobar lung, simultaneous pancreas-kidney, small intestine, and combined small intestine-liver.

MPSERS members utilize the Blue Quality Centers for Transplants.

Centers of Excellence (COE)

BCBSM offers three COE/disease specific programs including the Cardiac COE, the Oncology Care Program and the Blue Quality Centers for Transplants.

Michigan Cardiac COE. This program was established in 1996 to help members make more informed decisions in selecting a quality hospital able to meet their cardiac care needs. The network is comprised of 10 select hospitals whose cardiac programs and staff have met BCBSM's established quality criteria, earning them the Centers of Excellence designation.

Michigan Oncology Care Program. The BCBSM Oncology Care Program includes 20 hospitals that have been approved by the American College of Surgeons Commission on Cancer and are committed to clinical performance measurements and improvement.

Disease Management (DM)

Disease management programs provide additional services and targeted interventions to individuals who have diseases or conditions that can benefit from behavioral modification. We found that there was a wide range of DM services that are provided to school employees. As most of the school employees are covered by BCBSM, these DM services are provided on a consistent basis.

BCBSM's DM program covers asthma, diabetes, chronic obstructive pulmonary disease (COPD), ischemic heart disease, cancer, congestive heart disease and back pain. These programs are provided at no extra charge to customers. BCBSM estimates that these programs generated savings of \$25 million in 2004, representing a return on investment of close to 2 to 1.

BCBSM manages the Disease Management program for members of MPSERS. The DM program covers asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, hypercholesteremia, low-back pain, oncology (breast, lung and prostate), benign uterine conditions, benign prostatic hyperplasia, knee pain, hip pain, and revascularization.

Civil Service relies on the efforts of the HMOs and the BCBSM for disease management services.

Medical Necessity

Under BCBSM, the medical necessity of a technology, device or health care service is determined by the BCBSM Uniform Medical Policy Committee, which is comprised of physicians, nurses, pharmacists, and customer service, marketing and legal department personnel. Committee decisions are based on, but not limited to, evidence-based medicine guidelines, documentation and recommendations from appropriate professional organizations, and independent medical consultants with expertise in the area under review, regulatory, legislative and research documentation. Pre-certification and pPre-authorization are tools used to determine medical necessity of a member's claim. These decisions are based on InterQual criteria, standard of care guidelines, evidence based guidelines and the reviewers' clinical judgment.

BCBSM manages this function on behalf of MESSA. In cases involving member appeals of full or partial claims denials, MESSA, in conjunction with BCBSM, BCS and MESSA's Medical Director, determines medical necessity consistent with accepted standards for good medical practice.

BCBSM manages this function for members of MPSERS, SET SEG, as well as the Civil Service.

Claims Audits

Claims audits are thorough reviews of a sample of a plan sponsor's claims. The purpose of the audit is to verify whether the contract provisions are being administered appropriately.

For education customers of BCBSM, any groups of over 100 lives can audit BCBSM's claims and eligibility records. Claim audits by independent firms are allowed with the approval of BCBSM's Director of Internal Audit and Review's office.

BCBSM conducts internal audits of hospitals, catastrophic cases, claims for unusual services, and prescription drugs. There are also audits for outpatient services and for site of care criteria. BCBSM performs this function for MESSA. However, in addition to BCBSM's audit services,

MESSA reviews specific treatment utilization subject to contract (certificate) limits and guidelines.

SET SEG contracts with a vendor to perform claims audits for SET SEG school districts that have more than 100 covered lives and are either self-funded or experience rated.

Civil Service's contractual language includes scheduled audits every two years.

Criteria for Conducting Claim Audits

BCBSM's Quality Control performs post payment audits of all BCBSM claim processing systems on a weekly basis. Separate samples are reviewed for facility and professional services using the following strata: \$0-\$500, \$500-\$2,500, \$2,500-\$25,000, and \$25,000 and over. The sample size of each dollar strata is designed to meet a 95% confidence and a precision of +/- 3%.

Client specific claim reviews are conducted at the request of the Account Manager.

MESSA relies on the BCBSM claims audit process.

MPERS uses an outside consultant that audits randomly selected claims for each calendar year of paid claims.

Frequency of Pharmacy Claims Audits

BCBSM audits ask about one-fifth of the network each year. This includes on-site audits and direct-to-patient mailings, which ask the patient to confirm that the indicated services have been provided. MedImpact system audits are done daily and desktop audits monthly.

MESSA relies on the BCBSM claims audit process.

MPERS audits of retail pharmacies and the mail order pharmacy are completed on an ongoing basis by Heritage, a BCBSM subcontractor.

Collections of Ineligible and Unauthorized Claims

MESSA uses the services of the BCBSM fraud protection group for this function. MESSA recovers overpayments by offsetting future claims.

BCBSM manages this function for MPERS.

BCBSM manages this function for the Civil Service; however Civil Service may pursue collection in cases where BCBSM was unsuccessful.

Prescription Drugs

BCBSM has contracted with MedImpact to process pharmacy claims. Members use the BCBSM network for prescription drug claims incurred in Michigan and MedImpact for prescription drug claims incurred outside of Michigan. Medco processes mail order prescription drug claims.

Pharmacy benefits for MPSERS members are managed by BCBSM.

DPS has carved out the prescription drug benefit across all plans. The benefit is self-funded and currently administered by Caremark. DPS reports that this change saved about \$3.5 million before making any plan design changes and has allowed DPS to hold increases in drug costs to two percent annually over the last two years.

Coverage for SET SEG school districts with fewer than 100 covered lives uses BCBSM. For school districts with more than 100 covered lives, pharmacy coverage can be provided through one of two PBMs: Pharmacare or EHIM.

In the early 1990's, Civil Service carved out pharmacy benefits and has bid this coverage several times over the past fifteen years. The coverage is currently contracted with Express Scripts. The plan now has a mandatory generic substitution requirement (except for physician "dispense as written" scripts) as well as a mail order program.

Formularies

A prescription drug formulary is a list of preferred medications that have been chosen by the pharmacy benefits manager. Typically, formularies are developed to steer members and their physicians to cost-effective or discounted drug alternatives. Formularies have proven to be cost-effective means of lowering prescription drug costs. Unrestricted access to prescription drugs is termed "open access."

BCBSM has both open access and closed formularies as available options.

MESSA plans do not use formularies.

MPSERS uses the BCBSM Custom Formulary.

SET SEG provides a range of plan choices, including three tier coverage using formularies.

Civil Service uses a standard Express Scripts formulary.

DPS used a standard cove mark formulary.

Use of Generic Drugs and Mail Order Prescription Drug Delivery

Brand name drugs cost more than generic drugs, even though, in most cases, generic drugs are recognized to be identical to its brand name equivalent. Nevertheless, anxieties about generic drugs have made it difficult to convince members and doctors of the efficacy of generics and, hence, to reduce prescription drug costs. Table 2.7 summarizes the prevalence of generic drugs filled at retail pharmacies.

TABLE 2.7	
Plan Administrator	Percentage of Scripts Filled with Generic Drugs (retail)
MESSA	40%
BCBSM	48%
DPS	50%
MPERS	50.7%

Prescription drug costs can be significantly reduced when members order their prescription drugs through a mail order facility, rather than from a retail pharmacy, because of economies of scale obtained by mail order facilities. Although it takes somewhat longer to obtain drugs from a mail order facility, these facilities are an excellent source of renewal prescriptions. Changing the way people purchase prescription drugs has proven to be a significant challenge to plan sponsors and administrators. Nevertheless, an effective mail order drug program is essential to reducing and holding down prescription drug costs. Table 2.8 shows the prevalence of prescriptions filled through mail order facilities.

TABLE 2.8			
Plan Administrator	Percent of Scripts Filled By Mail Order	Percentage of Scripts Filled with Generic Drugs (mail order)	Percentage of Scripts Filled with Formulary Brand Drugs (mail order)
MESSA	12.5%	33%	67% (no formulary)
MPERS	24.4%	45%	41.5%

Contracts with pharmacy benefit managers usually specify the discount from a prescription drug's average wholesale price (AWP) that will apply to members covered under the contract. Generally the larger the purchasing group, the deeper the discount. Table 2.9 shows the discounts reported by the plan administrators.

TABLE 2.9		
Plan Administrator	Discounts at Retail	Discounts at Mail Order
BCBSM		AWP -23%
MESSA	Uses BCBSM standard plan	
MPSERS	AWP -16% (brand) Maximum Allowable Cost (MAC) or AWP -25% (generic)	AWP -23% (brand) Lesser of MAC or AWP -62% (generic)
Civil Service	Lower of AWP -16% or Usual customary and reasonable (UCR)	AWP -24% (brand) AWP -50% (generic)

Mental Health and Substance Abuse

Treatment of nervous and mental problems, and treatment of substance abuse, have been historically high-cost services, with little effective control, particularly in light of the wide range of possible treatments and treatment settings. To ensure proper care and control costs plans need utilization review and case management of these types of cases.

BCBSM Mental Health Services contracts with Magellan Behavioral Health for the provision of mental utilization review and case management services.¹² BCBSM Traditional and PPO products require telephone pre-authorization for inpatient and day treatment mental health and hospital-based substance abuse admissions. Pre-certification and level of care are determined using Magellan criteria adapted for BCBSM. Members may access outpatient care at BCBSM participating psychiatrists and participating outpatient clinics.¹³ Pre-authorization is not a requirement for outpatient settings for BCBSM Traditional and PPO products.

For MESSA Super Q 100, Choices, and Tri-Med plans, Magellan Health Services/Behavioral Care Management acts as a case manager to determine the most effective treatment and as a source of provider referrals for members.

MPSERS uses BCBSM Mental Health Services.

Civil Service has contracted directly with Magellan Behavioral of Michigan and has been quite satisfied with the arrangement. The coverage has been re-bid three times since the early 1990's, and per member costs have increased only 20 percent in the last 10 years.

¹² The Magellan Behavioral Health office which manages this business, is located in Farmington Hills, Michigan, in accordance with a BCBSM contract requirement.

¹³ BCBSM contracts and credentials approximately 456 outpatient clinics in Michigan.

Specialty Vendor Contracts

BCBSM has specialty vendor contracts for lab (Quest Diagnostics), radiology management (AIM), and chiropractic. In addition, it has subcontracted Durable Medical Equipment and Medical Supplies with Wright and Filippis.

Civil Service carved out lab and podiatry in the early 1990's, however member experience was not satisfactory and these arrangements were terminated.

III. STATE SYSTEMS

A. Michigan Public School Employees Retirement System (MPERS)

The operations of the Michigan Public School Employees Retirement System (MPERS) were of interest for this study for several reasons. First, albeit a much different demographic group, the retirees covered by MPERS are in a state-wide health care system that is fed by active school district employees. With appropriate demographic adjustments, the cost and administration of MPERS health care benefits provide a useful comparison to the potential cost and administration of benefits for a state-wide system for active school employees.

A second reason for our interest in MPERS is that one possible mechanism for administering a state-wide plan would be to expand MPERS' health care program to include active school district employees as well as retirees.

All former school employees receiving retirement benefits from MPERS are eligible to participate in the MPERS health plans. The primary source of funding for these retiree health plans is a percentage of payroll contribution paid by the school districts for each enrollee. The schools contributed 6.55 percent of payroll in 2005. Most MPERS pension recipients receive fully-paid medical insurance and 90 percent paid dental, vision and hearing plans. Certain vested retirees and surviving spouses and other dependents contribute a portion of the cost of the medical plan.

At MPERS changes in benefits are made through a structured seven step process that begins with staff recommendations to the Board's Health Insurance Committee (HIC). The HIC and staff then delivers the recommended initiative to the Board and request that a Health Initiative Review Committee (HIRC) be scheduled to review the new initiative. The HIRC will meet at least once and could meet multiple times depending on input from interested parties. The HIRC meets in a public setting and all Board meetings are open to the public. After consideration of input a final recommendation is presented to the Board/Department of Management and Budget for a final decision.

The MPERS Board is composed of 12 members representing different groups of stake-holders in the program such as retired teachers, school superintendents and the public. The Governor appoints 11 of the Board members and the State Superintendent of Education is an ex-officio member.

There were 110,000 retirees covered in the MPERS health plans in 2003 and 111,000 in 2004. The benefits provided by MPERS are summarized in Table 3.1.

TABLE 3.1		
Michigan Public School Employees Retirement System Health Benefits for Retired School Employees		
Type of Care	In-Network	Out-of-Network
Plan Deductible	\$235	\$235
Maximum Out-of-Pocket Limit	no maximum out-of-pocket	no maximum out-of-pocket
	Coinsurance	
Inpatient Hospital	100%	80%
Physician Visits	90%	70%
Specialist Visits	90%	70%
Surgical	100%	80%
Preventive Services	fully covered with few exceptions	covered with copayments
Mental Health and Substance Abuse Treatment – Inpatient	90%	Not covered
Mental Health and Substance Abuse Treatment – Outpatient	50%	Not covered
Dental	95%	90%
	Prescription Drug Coverage	
Coverage for Preferred and generic	20 % copayment with a \$7 minimum and \$30 maximum	
Coverage for Non-Preferred	40% copayment	
Coverage for Brand-name	Same copayments as above plus difference between brand-name and generic if generic is available.	

Routine vision care (eye exams, frames, lenses) are not covered under the plan. Dental care is not provided under the plan.

We measured the MPSERS benefits using the same BVC yardstick that was used for the school plans for active employees. Use of the standard BVC automatically adjusts for demographic differences between the active and retired school employees. Table 3.2 compares the BVC values of the active and retired school employee benefits. The MPSERS benefits value is lower than all but one of the active employee benefits packages. The main reason for the difference is that the deductible and prescription drug copayments are higher than for most of the school employee plans.

TABLE 3.2		
Retired and Active School Employee Benefits		
Name of Plan	Type Of plan	BVC Value
Blue Choice POS	POS	4,357
MPSERS	PPO	4,683
Ultra Med Preferred 1	PPO	4,896
Community Blue PPO	PPO	5,176
MESSA Choices II	PPO	5,191
Blue Managed Traditional	FFS	5,247
MESSA Choices	PPO	5,258
MESSA Tri-Med	PPO	5,329
MEBS	FFS	5,515
MESSA Super Care I (average)	FFS	5,800

B. Michigan Civil Service

Health benefits for state employees are provided through the Michigan Civil Service system, and administered by the Department of Civil Service, subject to the oversight of the Civil Service Commission. Of the 53,748 state employees at the end of 2004, 49,624 were enrolled for medical benefits, 50,010 were enrolled for dental benefits, and 50,081 were enrolled for vision benefits.

Three types of medical coverage are available through: a BCBSM PPO option, a variety of HMO plans, and a high-deductible plan.¹⁴ Sixty percent of Michigan state employees choosing medical coverage are enrolled in the BCBSM PPO. Most of the rest are enrolled in an HMO; less than 1,000 state employees are enrolled in the high-deductible plan. The PPO option is self-funded; all of the HMO contracts are fully insured.

Prescription drug coverage has been carved out, and is provided on a self-insured basis through Express Scripts, a national pharmacy benefit manager. Mental health coverage has also been carved out, and is provided through Magellan. Dental benefits are provided through Delta Dental, and vision benefits are provided through BCBSM.

The employee contribution is collectively bargained for union employees, and established as part of the annual pay-setting process for non-union employees. All contribution rates are reviewed and approved by the Civil Service Commission. Currently, the state pays 95 percent of the cost

¹⁴ High-deductible plans typically have lower premiums because the large initial cost of health care (up to the deductible amount) is paid by the employee.

for the self-insured PPO option. The state will pay up to that amount towards HMO coverage, with the employee contribution making up any remaining cost.

C. Other States

We surveyed the health plans of school employees in 15 states for this report. These include states close to Michigan as well as others that are of particular interest. Two of the states provide mandatory health insurance for all school district employees through a state-wide health plan (Delaware and South Carolina), one state requires participation of small school districts in a state-wide plan (Texas), and ten states (including Texas for large school districts) permit school districts to voluntarily participate in the state health plan for state employees. The remaining three states surveyed do not permit school districts to participate in state-wide plans. Table 3.3 summarizes the coverage for the 15 states surveyed.

TABLE 3.3			
Summary for School Health Plan Design for School Employees			
State	Mandatory Participation in a State-wide Health Plan	Voluntary Participation in a State-wide Health Plan	No State Health Plan for School Employees
California		X	
Delaware	X		
Georgia		X	
Illinois		X	
Kentucky		X	
Louisiana		X	
Maryland			X
Minnesota		X	
New Jersey		X	
New York		X	
North Carolina	X		
Ohio			X
Pennsylvania			X
South Carolina		X	
Texas	For school districts of less than 500 employees	For school districts of more than 500 employees	
Wisconsin		X ¹⁵	

¹⁵ Only a handful of Wisconsin school districts have elected to participate in the health plan for state employees.

California

California permits active school district employees to participate in the CalPERS state-wide health plan.

Eligible retired teachers may participate in the California State Teachers Retirement System (CalSTRS) health ¹⁶care program that pays Medicare Part A premiums.

The CalPERS Health Benefits Program was established for state employees in 1962 by the Public Employees' Medical & Hospital Care Act. Participation was extended to other public employers such as cities, counties and school districts in 1967. CalPERS covers more than 100 school districts, which accounts for more than 70,000 employees (approximately 18% of the approximately 550,000 covered employees). CalPERS is one of the largest purchasers of employee health benefits in the United States.

CalPERS provides health care benefits through PPOs, HMOs, and Exclusive Provider Organizations (EPOs). Availability of the three types of plans depends on where the school employee lives and works. More specifically, CalPERS uses a state-wide premium pool for each health plan option, and then varies the premium rates based on family size. The following CalPERS health care plans are available to active school employees in participating districts.¹⁷

- PPOs: PERSCare, PERSChoice
- HMOs: Blue Shield Access + HMO, Kaiser Permanente, Western Health Advantage
- EPO: Blue Shield EPO.
- CalPERS offers a variety of retiree health care plans to supplement Medicare, including a PPO, HMO, and EPO, and Medicare+Choice.

The two most popular plans are the Blue Shield Access + HMO and the Kaiser Permanente HMO. Together they make up two-thirds of the enrollments.

In California, the Board of Administration manages the CalPERS program for both retirement and health insurance. The Board consists of a total of 13 members. Six of the members are elected, three are appointed (two by the Governor), and four hold state offices (*i.e.*, Treasurer, Comptroller, Director of State Personnel, and a designee of the State Personnel Board). The Board's responsibilities include setting employer contribution rates, determining asset allocations, and providing actuarial valuations with regard to their health and retirement programs as well as various other program benefits available. Changes cannot be made to the benefits without the approval of the State Legislature.

¹⁶ Retired teachers eligible for CalSTRs are those who retired prior to January 1, 2001 and are receiving a monthly CalSTRS allowance, those not eligible for premium-free Medicare Part A, and those enrolled in Medicare Parts A and B at age 65.

¹⁷ Some CalPERS health care plans are available only certain groups of employees such as highway patrolmen, firefighters, and correctional officers. These plans are not shown.

Delaware

Delaware is one of two states surveyed that requires all of its state's school districts to provide health care benefits to its employees through a state-wide health plan.

The State of Delaware is required to provide employee health benefits through the State of Delaware Group Health Insurance Program (Delaware GHIP) to local school district employees, as well as employees of the State and local governments (collectively denoted below as government employees). Delaware GHIP provides medical and prescription drug coverage. Dental and vision benefits for government employees are available but the employee must pay the full cost. Also, some school districts offer employee-paid dental and vision plans. School employees may also subscribe to a separate district-sponsored prescription drug plan, which would be in addition to the Delaware GHIP plan, as part of the employee's medical coverage.

Coverage in the Delaware GHIP medical/prescription drug plan is for active employees and retirees. Retirees and their dependents must enroll in Medicare Parts A and B when they become eligible or their coverage under the Delaware GHIP medical plan will terminate.

Several levels of medical coverage are available, as described in the following section. The State pays the full cost for the Basic level of coverage after three months of service. The school district may pay a share of the premium in the interim.

Medical benefits are delivered through five plans:

- Blue Cross Blue Shield of Delaware plans:
 - Basic (traditional indemnity)
 - First State (traditional indemnity)
 - Comprehensive PPO
 - BlueCare (HMO)
- Coventry Health Care (HMO)

The prescription drug benefit is provided through Express Scripts. The Basic plan does not include prescription drug coverage.

The Delaware GHIP was established by state statute, which also established a state employee benefits committee, which governs the Delaware GHIP. The committee, which meets quarterly, consists of certain senior-level state officials, including the director of state personnel, the state's human resources officer, and the comptroller. The committee determines benefits and premiums. The State Personnel Office's Division of Benefits administers the Delaware GHIP.

Georgia

The State of Georgia permits, but does not require, school districts to participate in the Georgia Public Employees Health Benefits programs, including the State Health Benefit Plan (GA-SHBP). GA-SHBP covers approximately 2 million lives, of which school district employees and retirees and their dependents constitute approximately 450,000.

School districts may elect to participate in the GA-SHBP. If a school district does not elect to participate, the school district may be required to participate if at least 75% of the employees petition to participate.

To be eligible under the GA-SHBP, a school district employee must be employed at least 60% or work at least 15 hours per week on a regular, non-emergency basis.

GA-SHBP offers a variety of plan options, including an indemnity plan, a high and low PPO, a high and low HMO, and a Medicare+Advantage plan for Medicare-eligible retirees. School district employees overwhelmingly prefer the low-option PPO, with the PPO high-option (offered through BlueCross BlueShield of Georgia) the second most popular.

The Georgia Department of Community Health has within it the Division of Public Employee Health Benefits, which administers all the state-sponsored health and welfare plans available to state employees and other governmental employers. The GA-SHBP is the health plan operated by that Division. The Commissioner of the Georgia Department of Community Health is the chief administrative officer of the GA-SHBP and the other benefit programs under that Department's control.

GA-SHBP is governed by the Board of Community Health, which is established pursuant to state statute. The Board establishes subscriber and employer rates.

Illinois

Illinois school districts are permitted, on a voluntary basis, to participate in the Local Government Health Plan Option (IL-LGHPO); however, as explained below, few participate.

School districts are eligible to participate in the same health plan offered to employees of local governments, state agencies and instrumentalities. The self-funded health plan uses a single experience pool for rating purposes, and the same rates apply to all participating employers. There are three rate groups: single, single + one dependent, and family.

Of the hundreds of school districts in Illinois, only approximately 20 school districts participate in the IL-LGHPO. According to a Department of CMS representative, there are a few key reasons why very few Illinois school districts participate in the IL-LGHPO: (1) the IL-LGHPO is a "very rich plan," which may cost more than some school districts are willing to pay; (2) under the eligibility rules, a husband and wife who are both eligible employees cannot enroll in family coverage in the IL-LGHPO, unless at least 85% of the eligible employees in the school district

participate; (3) although employers may leave the IL-LGHPO, they cannot return for three years; and (4) no life insurance is available through the IL-LGHPO.

The IL-LGHPO provides a variety of plans including several regional HMOs, a PPO, and a traditional indemnity program. They also offer an open access program that contains HMO, PPO, and indemnity features.

In 2004, the Illinois State Legislature authorized the establishment of a prescription drug plan that school districts could purchase separately. The program has not yet begun.

The IL-LGHPO is controlled and managed by the Central Management Services for Illinois (Department of CMS). More specifically, IL-LGHPO operations are governed by the Bureau of Benefits, within the Department of CMS. The Department of CMS serves as a centralized coordinator and provider of services and resources to local governments, state agencies, and school districts.

Kentucky

The State of Kentucky's Public Employee Health Insurance Program (KY-PEHIP) permits school districts, on a voluntary basis, to participate in the KY-PEHIP.

KY-PEHIP covers active and retired employees of the State, local governments, and State instrumentalities, including school districts. Approximately 112,000 school district employees are covered by KY-PEHIP.

KY-PEHIP establishes premiums in eight regions around the State. Within each region, carriers' rates vary. Not all carriers are available throughout the entire State. There are three health plans from which eligible employee may choose: "Essential" (lowest cost), "Enhanced" (mid-cost), and "Premier" (highest cost). Also, there are separate, higher rates for smokers.

Appeals are processed by the Department of Employee Insurance, which is a part of the Personnel Cabinet.

The Kentucky Group Health Insurance Board was established by State statute in 2000 to develop recommendations for benefit options and management of KY-PEHIP. The Board's recommendations are forwarded to the Governor and the State General Assembly for action. The Board consists of 13 members, including State senior executives and various appointees.¹⁸

¹⁸ Specifically, the Board consists of: the Secretary of Finance and Administration, the Secretary of Personnel, the Budget Director, Commissioner of Education, Chair of the Advisory Committee, the Commissioner of Insurance, the State Auditor, the Director of Administrative Office of the Courts (or designee), a retiree appointed by the State Retirement System, a representative of the Teacher Retirement System, a representative from the largest teachers' union, a representative of State employees, and a representative of State classified employees.

Louisiana

Although school district participation in the Louisiana state-wide health plan is voluntary, a significant majority of Louisiana school districts participate in the state-wide health plan.

Since 1980 the State of Louisiana has made available, on a voluntary basis, a uniform benefit program (health and life insurance), provided through the State Office of Group Benefits (Louisiana OGB), to cover school district employees, in addition to employees in all other State agencies. The program has been self-insured since 1976, and is financed on a pay-as-you-go basis. There are approximately 250,000 covered active and retired employees covered by the Louisiana OGB. Of that number approximately 50,000 are active and retired school employees.

Nearly 69 percent (44 of 64) of the parish/city school boards participate in the Louisiana OGB program. Non-participating school boards are responsible for providing health benefits for their employees.

Active and retired employees of participating parishes/cities are eligible for coverage. To qualify for retiree health care coverage, the retiree must be enrolled in the Louisiana OGB health care plan at the time of retirement.

Health care coverage includes medical, prescription drug, dental, and vision. The dental and vision benefits are provided in the form of discounted services from preferred provider networks. The dental and vision benefits are not insurance products.

The State shares in the cost of medical insurance for active and retired employees. The percentage of the total premium that is paid for active employees ranges from about 75% for single coverage to 62% for family coverage, depending on the plan. The percentage of cost paid for retirees is based on years of participation in the plan. The percentage of the State's share of the premium for retirees ranges from 19% with 10 or fewer years of participation to 75% with 20 or more years of participation.

The Louisiana OGB's benefit costs exceed \$1.1 billion per year.

Medical benefits for active and retired employees are delivered through three state-wide plans (a PPO, an EPO, and an MCO) and two HMO plans that cover participants in nine regions of the State.

The state-wide plans are self funded and the HMOs are fully insured. The three state-wide plans are part of a single risk pool and the premiums are actuarially established to meet the anticipated health care costs generated by participants in these plans. The premiums for the two regional HMOs are established by the HMOs, and the State collects the premiums and transmits them to the HMOs.

The Louisiana Legislature has restructured the control of the Louisiana OGB since its inception in 1979. As originally conceived, the Louisiana Legislature created the OGB as an autonomous authority, subject to a partially elected and partially governor-appointed board of trustees. In

2002 the Louisiana Legislature put the OGB under the direct control of the State's Division of Administration, which controls most of the executive branch of State government. More specifically, the OGB has a chief executive officer appointed by the Commissioner of Administration, who runs the Division of Administration, and is appointed by the governor. The OGB also has a Policy and Planning Board, which has only the power to make recommendations to the OGB's chief executive officer. All final decisions pertaining to the OGB must be approved by the Commissioner of Administration. The OGB's Policy and Planning Board discusses health care and plan design issues, monitors activities of the OGB's chief executive officer, but the Board has no direct power or control over the OGB plans or premiums, all of which must ultimately be approved by the Commissioner of Administration. The Policy and Planning Board consists of 14 members, some of whom are elected from various constituencies and some are governor-appointed. Apparently, the restructuring was done to give the State more direct control over health care benefits.

Maryland

Maryland does not permit school employees to participate in any state-sponsored health plan, primarily because of the size and structure of Maryland's school districts. Maryland school districts are organized exclusively on a county basis, so that each county school district has its own health plans for its own employees. Even the smallest counties employ more than 1,000 employees while the largest employ closer to 50,000. Consequently, Maryland obtains economies of scale in the cost of school employees' health care coverage as a function of school systems' county structure.

Minnesota

Minnesota permits school districts to participate in the Public Employer Insurance Program (PEIP), a state-wide health plan for local governments, governmental agencies, and school districts. However, only 19 of Minnesota's 341 school districts (5%) participated in PEIP in 2002. In 2004, the Minnesota Legislature established a committee and commissioned a study to determine whether Minnesota should provide some type of state-wide health plan for school district employees. The committee endorsed a variety of state-wide solutions, with the majority supporting one mandatory state-wide, self-insured health plan for all school district employees. It was estimated that a single mandatory plan would reduce projected total costs by 4.1% on a present value basis. As of the 2001-02 school year, 54% of Minnesota's 341 school districts used Blue Cross Blue Shield of Minnesota for health benefits.

New Jersey

New Jersey permits, but does not require, school districts to participate in the same health plan provided to state and local government employees. A significant number of New Jersey school districts take advantage of this opportunity.

Local school districts are eligible to participate, on a voluntary basis, in the State Health Benefits Program (NJ-SHBP) that covers state employees and those local governmental organizations that apply for membership. NJ-SHBP was extended to local public employers in 1964.

Approximately 300 of 665 (47 percent) of New Jersey school districts participate in NJ-SHBP. The remaining districts contract directly for employee health benefits, most using CIGNA.

Employees and retirees of school districts that participate in NJ-SHBP receive medical and prescription drug benefits. NJ-SHBP dental and vision benefits are not available to school employees.

Eligible active employees must be full time as defined by the employer to be eligible for benefits. Eligible retirees who were covered by NJ-SHBP during active service are covered after retirement as long as they work up to their retirement date. Retired teachers who participated in the Teacher's Annuity and Pension Fund, or school board employees who participated in the Public Employees Retirement System and served 25 years, or who retire on a disability retirement, are eligible for retiree health care coverage even if their employers did not participate in NJ-SHBP. This includes those who elect a deferred retirement with 25 or more years of service credit in the pension fund.

Medical benefits are delivered through a variety of plans, including an indemnity plan, a POS, and several HMOs. In total, the NJ-SHBP covers more than 80,000 active school employees and 55,000 retired school employees.

NJ-SHBP is governed by the State Health Benefits Commission which is the executive body of the plan established by statute. Daily administrative activities of the NJ-SHBP are handled by the Division of Pension and Benefits. Plan members are provided the opportunity to appeal to the Health Benefits Commission for resolution of any complaints with their plan, after they have completed the formal grievance process with their plan administrator. The state Division of Pensions and Benefits is responsible for administration of NJ-SHBP.

New York

In 1957, the New York State Health Insurance Program (NY-SHIP) was established to provide health care benefits to state employees. A year later, in 1958, the program was opened to local governments, school districts, and municipalities. NY-SHIP is one of the largest public employer health insurance programs in the nation, covering over 1.1 million state and local government employees, retirees, and their families.

School employees in the State of New York, with the exception of New York City, receive health care benefits through their local school districts. These plans are generally bargained between the local school board and the employee's union. Employees of public schools in New York City obtain their benefits through the New York City Department of Education where basic coverage is of no cost to the employee. (See following description of New York City benefit Plan.)

Approximately 140 of 750, or 19 percent, of school districts in New York State participate in NY-SHIP. Employees/retirees in these districts receive the same health care benefits as State employees/retirees.

To be eligible for coverage in the NY-SHIP, active school employees must be expected to work for at least three months and work at least 20 hours per week or be paid at an annual salary rate of \$2,000 or more. Retired school employees must have at least five years of service (not necessarily continuous) with the school district, be qualified for retirement as a member of a retirement system administered by the State (*e.g.*, the New York State Teachers' Retirement System), and be enrolled in the NY-SHIP at the time of retirement.

NY-SHIP offers two levels of coverage: core benefits and core benefits plus enhancements. Local districts and the employee's unions determine the level of coverage and the premium sharing, subject to statutory guidelines.

The NY-SHIP benefit is insured and administered by several providers. Inpatient and outpatient hospital services are provided by Empire Blue Cross Blue Shield. Medical and surgical services are provided through United HealthCare. Prescription drugs are insured by CIGNA and administered by Express Scripts. Mental health and substance abuse benefits are insured by Group Health Insurance (GHI) and administered by ValueOptions.

The State sets the total premium. The NY-SHIP plans are experience rated. All participants, including local school district employees, are included in the group for rating purposes. School districts that participate in the NY-SHIP have been required by State law to pay at least 50 percent of the premium for individual coverage and at least 35 percent of the premium for dependent coverage. This premium-sharing arrangement applies to both active and retired employees.

The New York State Department of Civil Service Employee Benefits Division administers the program.

New York City school employees and retirees are covered under the New York City Health Benefits Program (NYC-HBP). NYC-HBP covers more than 500,000 City employees, at a cost of more than \$2 billion per year.

Active employees must work at least 20 hours per week to qualify for coverage. Retirees must have at least five years of creditable service as a member of a retirement or pension system maintained by the City, have been employed by the City immediately prior to retirement, and be receiving a retirement annuity from a City pension plan.

The NYC-HBP offers a variety of plans. Three basic options are available to active and retired employees and are fully paid by the City Department of Education.

Active school employees may elect optional benefits and riders under a variety of plans. Generally the optional coverage is a basic plan and the riders are for additional prescription drug coverage that reduces the out-of-pocket drug costs under the basic plan. Optional benefits require employee contributions for the basic coverage and the rider(s). Optional coverage for active employees has been offered through Aetna, Cigna, Empire BCBS, Group Health Insurance (GHI), and others.

Retired New York City school employees may enroll in a variety of plans, depending on their eligibility for Medicare. The City reimburses eligible City retirees and their dependents for their Medicare Part B premiums, provided they are enrolled in Part B. Medicare-eligible retirees who enroll in a Medicare HMO plan receive enhanced prescription drug coverage from the Medicare HMO if their union welfare fund does not provide prescription drug coverage, or does not provide coverage deemed to be equivalent, as determined by the NYC-HBP, to the HMO enhanced prescription drug coverage. The retiree pays for this coverage through payroll deductions from their pensions. Eligibility for the optional drug coverage is determined automatically, and is not a discretionary election for the retiree.

North Carolina

North Carolina is one of two states surveyed that requires all school districts to participate in a state-wide health plan. Through the provisions and limitations of the North Carolina General Statutes, the state provides mandatory health care benefits to active and retired State employees as well as for school district employees, retirees, and their eligible dependents. The North Carolina State Health Plan (NC-SHP) pays more than \$1.1 billion annually in benefits and covers more than 550,000 lives.

The NC-SHP covers the full-time permanent employees of all state and local governments, agencies, and instrumentalities, including all school districts. The state pays the full cost of single coverage. Those non-full-time employees working 20 hours per week or more may participate in NC-SHP at their own cost. There are three tiers of coverage: employee, employee + children, and family. The state pays 100% of the cost for employee-only coverage. All other costs are borne by the employee.

School district retirees may continue coverage under NC-SHP, up to and beyond Medicare eligibility. Retirees also receive State-paid coverage for themselves if they have been contributing members of the Teachers' and State Employees' Retirement Systems for at least five years and are receiving retirement benefits. Otherwise, retirees can pay the full cost and receive coverage. Retirees may purchase coverage for eligible spouses and dependents.

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan provides health care benefits for active and retired school district employees. Health coverage in the major medical plan (a PPO) includes medical and prescription drugs. School district employees are not covered under the state's dental care and vision services; however, the school districts may obtain their own coverage for dental and vision.¹⁹

The health plan is self-funded. BlueCross BlueShield of North Carolina is the claims administrator. The health plan provides access to network and non-network health care providers.

¹⁹ Only state employees are eligible to purchase dental and vision coverage through the state's flexible benefits plans (NCFLEX).

Health benefits for North Carolina school district employees are based upon legislation enacted by the North Carolina General Assembly.²⁰ NC-SHP is run by a board of trustees and an executive administrator; however neither has the power to unilaterally change plan design or other aspects that have been established by State statute. The board of trustees consists of nine members: 3 appointed by the Governor, 3 by the General Assembly upon the recommendation of the State Speaker of the House, and three by the General Assembly upon the recommendation of the Speaker Pro Tempore of the State Senate. The Executive Administrator of NC-SHP is appointed by the Commissioner of Insurance.

Ohio

Ohio does not permit active employees of school districts to participate in the state employee health plan school district. However, the State's two retirement systems provide retiree health benefits to their respective school district members.

Health benefits for retired school district teachers and their surviving family members are provided through the State Teachers Retirement System of Ohio (STRS). Under the STRS, a retiree must have 15 years of service to qualify for retiree health benefits. STRS retirees may choose among an indemnity plan and several HMOs and PPOs.

Health benefits for retired non-teaching school district employees are provided through the School Employees Retirement System of Ohio (SERS). Retiree costs are determined on a sliding scale, requiring a retiree to pay 75 percent of premiums if she/he has 10 years of service, and grading down to no cost for retirees with 25 or more years of service. Under SERS, school districts pay a percentage of payroll as a surcharge. Retirees may choose among three HMOs and two PPOs.

South Carolina

South Carolina offers its school districts the option of participating in the South Carolina state and local government Employee Insurance Program (SC-EIP). The SC-EIP provides health (including prescription drugs), dental, life insurance, long-term disability, and long-term care benefits, a flexible benefits arrangement, and a vision discount program.

The SC-EIP is the health and welfare benefit program for state employees and those local governments, agencies, instrumentalities, and school districts that elect to participate. Generally, employees who work at least 30 hours per week on a permanent, full-time basis are eligible to participate; however, participating employers have the option to reduce the general eligibility threshold to 20 hours per week. In addition, permanent part-time teachers who work at least 15 hours per week are eligible.

SC-EIP offers two PPOs, several regional HMOs, and one retiree program. One of the PPOs is an eligible high deductible health care plan, which is coupled with a health savings account (HSA). Employees who enroll in the eligible high deductible plan may contribute to the HSA on

²⁰ See Chap. 135, Article 3, Parts 1-5 of NCGS.

a tax-exempt basis, subject to certain federal restrictions. The other PPO is a traditional design plan, with deductible and copays. SC-EIP sponsors several regional HMOs, one of which includes a point-of-service feature, which allows subscribers to access non-network providers. Lastly, SC-EIP sponsors a retiree health program. BlueCross and BlueShield of South Carolina administers the self-insured PPOs.

The SC-EIP is governed by the South Carolina Budget and Control Board (the Board) which is the central administrative agency for South Carolina. In addition to operating the state retirement system and the SC-EIP, the Board supports other state and local government functions including procurement, fleet systems, and the purchase of liability insurance. The Board consists of five *ex-officio* members: the Governor, as chairman, the Treasurer, the Comptroller General, the chairman of the State Senate Finance Committee, and the chairman of the State House Ways and Means Committee. The Board selects an executive director, who serves as the agency's chief administrative officer.

Texas

The other states that we surveyed that provide a state-wide plan for teachers do so by adding the school employees to the state employee's health plan. However Texas created a separate state-wide health system for school district employees independent of the state employee's health plan. Depending on the size of the school district, Texas school district employees are either required or permitted to participate in the state-wide health system for school employees. The state-wide school district health program is administered by the Teacher Retirement System of Texas (TRS) and is called TRS – ActiveCare. TRS also administers a separate health benefit program for retired school district employees called TRS – Care.

TRS – ActiveCare covers more than 250,000 lives, and TRS – Care covers almost 200,000 lives. TRS estimates the total potential number of lives is approximately 900,000. Thus, the two TRS plans cover approximately 50 percent of the potential population.

As of September 1, 2003, Texas law required that active employees of all school districts with 500 or fewer employees participate in TRS – ActiveCare, unless the school district was already self-insured as of January 1, 2001. School districts with more than 500 but not more than 1,000 employees have the option of participating in TRS – ActiveCare, but once they elect to participate, they cannot leave the program. Effective September 1, 2005 active employees of school districts with more than 500 employees are permitted, but not required, to participate in TRS – ActiveCare. Eight-five percent (1,039 of 1,234 school districts) participate in ActiveCare.

A school district employee is eligible to participate in TRS – ActiveCare if he or she is either (1) an active member of the TRS or (2) regularly works at least 10 hours per week.

TRS – ActiveCare is available only to active employees of Texas school districts. Retired school district employees may be eligible to participate in TRS – Care, which covers only retired school district employees. Employees of the State of Texas, its governmental units, and higher education employees are eligible to participate in their own state-wide health plan.

A TRS representative indicated that a separate health care plan was established for school district employees for several reasons, including: (1) that the method of payment for State employees is completely different than for school district employees, in that school districts receive a state subsidy in their school funding formula, whereas the State makes a direct payment to the health plan for State employees; (2) the demographics and utilization patterns for school district employees are significantly different than for State employees; and (3) the health needs (*e.g.*, need for disease management) for school district employees are different than for State employees.

TRS – ActiveCare offers eligible employees several HMO and PPO options to choose from. There are high, medium, and low-cost PPO options, all currently offered through BlueCross BlueShield of Texas; and four regional HMOs offered through various regional HMOs. State plan premiums are uniform across the state for each plan available to school district employees.

The Board of Trustees is responsible for the administration of the TRS – ActiveCare (for active school district employees) and TRS – Care (for retired school district employees) under Texas statutes. The Board approves the plan providers, the plan design, and the premium rates. However, Texas statute provides some parameters for the plan designs offered by TRS.

As specified by Texas statute, the Board is composed of nine trustees who are appointed to staggered terms of six years. Three trustees are direct appointments of the governor. Two trustees are appointed by the governor from a list prepared by the State Board of Education. Two trustees are appointed by the governor from the three public school district active member candidates who have been nominated for each position by employees of public school districts. One trustee is appointed by the governor from the three higher education active member candidates nominated by employees of institutions of higher education. One trustee is appointed by the governor from the three retired member candidates who are nominated by retired TRS members. Appointments are subject to confirmation by the Senate.

Wisconsin

Wisconsin school districts have the option of participating in the Wisconsin State Employee Trust Fund, which provides health benefits principally for State employees. However, only a handful of school districts participate in the State health plan.

The majority of Wisconsin school districts obtain their health and welfare benefits from the Wisconsin Education Association Insurance Corporation (WEAIC). WEAIC is a subsidiary of the Wisconsin Education Association (WEA), an affiliate of the National Education Association. WEAIC is a state-regulated insurance company, which covers 78% (332 out of 426) school districts.²¹ WEAIC provides insured medical, dental, short- and long-term disability coverage for school district employees, provided the school district has at least one group of employees represented by the WEA. WEAIC uses a separate pool rating for each participating school

²¹ Generally, WEAIC does not cover the State's largest school districts, which prefer to use their own self-insured arrangements.

district that takes into account the various demographic and experience factors, and regional cost factors specific to that school district.

Summary and Conclusions Regarding Other States' Practices

Our study of how 15 states deal with health care benefits for school district employees suggests several significant findings and trends. Of the 12 states that provide for the participation of school districts in state-wide health plans, only two – Delaware and North Carolina – require school district participation. A third, Texas, requires participation by school districts with 500 or fewer employees. In the case of Delaware, it is relatively easy to understand that approximately 20 small school districts would clearly benefit from participating in a state-wide plan. The evolution of the mandatory plan in North Carolina is a function of the particular facts and circumstances that led to a state-wide mandate. In all other states that provide for voluntary participation by school districts, except for Texas, state statutes were amended to permit school districts to participate in preexisting health plans for state employees. The preponderance of voluntary plans suggests the political reality of how difficult it is to compel school districts to participate in a state-wide plan. Texas determined that a separate state-wide plan exclusively for school district employees would make more sense, and that the plan should be administered by the Texas Retirement System, which already administered the health plan for retired school district employees.

The state-wide plans made available to school districts are commonly the same medical plans available to state employees, with Texas as a notable exception. In most cases, the state-wide health plans are administered through the state's executive branch, with a governing board consisting of various *ex-officio* members, appointees, and employee representatives. Independent governing boards usually have significant representation by Senior Executive branch Officers or their designees.

In states where unions are particularly strong, unions have significant influence or control over state-wide plans, and the state-wide plans tend to be structurally more autonomous. For example, in Pennsylvania, the state-wide health plan for state employees (which does not cover school employees) is governed by a board consisting of equal numbers of union and management appointees. Another approach used by the Michigan Education Association and Wisconsin Education Association, and to a lesser extent by the Pennsylvania State Education Association, has been to create their own subsidiaries, which provide health and welfare programs for school district employees. These union-affiliated programs typically are most popular in the non-urban parts of the state where finding competitive programs is more difficult.

Even when participation in a state-wide plan is made available to school districts on a voluntary basis, large school districts often desire to maintain their autonomy and independence. Whether or not these large school districts could achieve significant savings from participating in a state-wide plan depends on their particular plans. However, in our study of the Pennsylvania school district arrangement, we concluded that significant savings could be realized through the use of a consolidated plan, even without any changes in plan design. The tension between small and large school districts with respect to health care benefits, as with many other matters, is a critical

issue to be addressed by any potentially new arrangement for school district health care coverage.

State-wide plans seek to equalize premiums across large portions of the state, if not the whole state. States have come to different conclusions regarding whether, and to what extent, to adjust premiums for demographic and regional costs.

IV. COST ANALYSIS

A. Modeling

No one source of information is available that provides a complete picture of the current system for providing health benefits to school district employees. To provide a sound basis for understanding the costs of the current system and for modeling the impact of potential changes to that system, it is necessary to synthesize data from a number of sources. Hay's analysis is based on a combination of aggregate system-wide data, detailed information at the school district level, and benefit plan design and cost information from the principal insurers.

System-wide data on 2004 school employment levels were obtained from the Michigan Center for Educational Performance and Information. Aggregate data on enrollment, premiums, benefit payments and administrative costs were obtained from BCBSM, which cover the majority of school district employees. This was supplemented by the data from the March 2005 BCBSM rate filing for the fully-insured health plans marketed through MESSA, and the most recent Delta Dental rate filing for dental coverage marketed through MESSA.

School district level data were obtained through a survey of local public school districts, intermediate school districts, charter schools and community colleges. This survey provided detailed information on enrollment, benefits provided, program funding (*e.g.*, fully-insured versus self-funded) and any employee contribution requirements. We received 257 survey responses, including responses from large school districts such as Detroit and Grand Rapids. A few of the surveys were incomplete, resulting in a verified survey database providing usable information on 81,000 school district employees. The survey data were used to decompose the aggregate system-wide data by key study variables such as benefit plan and funding method.

We analyzed each benefit plan using Hay's proprietary BVC methodology. This approach allows us to compare directly the value of multiple benefit plans on a "common cost" basis that assumes a standard employee population and common financing method. Such an approach is critical, because the value *to an employee* of a benefit plan is independent of the financing method used by the employer, the level of administrative fees paid by the employer, and the demographics of the other employees enrolled in the plan. The BVC methodology is explained further in Appendix C.

To facilitate an understanding of the sources of potential savings and the key design options for a new system, we modeled aggregate system costs under three scenarios. First, we estimated the total cost of current benefits to provide a baseline. Second, we modeled the aggregate costs under a single state-wide system assuming that each school entity maintained its current health care benefit packages without any change in those benefit packages. Third, we modeled the

aggregate costs under a single state-wide system assuming that a common set of plan options was made available to school districts.²²

B. Comparison of Costs between Existing Funding Mechanisms

The cost of providing a given set of benefits to a specific group of employees will vary depending on the way the benefits are funded and administered. The approach taken to funding a benefit plan directly affects the level of non-claim expenses (i.e., the administrative “load” in excess of direct benefit payments). For instance, if a health benefit plan is fully insured the premium will include a risk charge by the insurer that would not be paid if the plan were self-funded. A self-funded school district with 300 employees would likely purchase stop-loss reinsurance; this would not be necessary for a self-funded district with 10,000 employees because the risk is sufficiently spread among a large population that significant variations in benefit costs can be adequately measured and taken into account for purposes of premium rate setting.

The cost of providing the benefits will also depend on how effective the organization administering the benefits is at managing their costs. Program management includes a wide variety of activities designed to ensure that enrollees received the benefits they need in as cost-effective manner as possible, and that no funds are wasted due to preventable administrative errors. Related to this is the ability to establish tailored programs designed to provide focused management of particular types of expenses – such as prescription drugs.

We analyzed the administrative costs and program management available under each of the existing funding mechanisms. Appendix C documents the development of the program cost savings.

System-wide Plan Administration

Through a series of interviews with the various stakeholders and benefit plan administrators, we learned that there is a significant variation in how benefits are administered. Thus, for a given set of benefits, the system-wide cost could be reduced by applying a uniform set of administration procedures, and the cost further optimized by using best practices for plan administration.

If Michigan establishes a state-wide health system for school district employees, we recommend that the administration of the system adopt the following best practices approaches.

²² This final analysis was performed for two different sets of plan options: one that included traditional fee-for-service plans, and one that did not.

Contract Negotiations and Provisions

The best practices would take full advantage of the size of the school district employees' health system, leveraging the system's purchasing power to obtain favorable contract provisions and member service guarantees. These contract provisions could include:

- Establishing a “most favored nation” clause in all vendor contracts. This would require the vendors to certify and guarantee that the fees charged are equal to or less than those charged to any similarly situated customer. If the vendor subsequently offers lower fees to any other customer, the vendor would have to reimburse the plan for the difference. To enforce this provision, the plan would require the vendor's senior financial manager to certify annually that fees charged to the plan are in compliance with this clause.
- The contract provisions would require a 100% cost and eligibility match before it will authorize the payment of carrier invoices. If the invoice includes claims for an ineligible person, the plan would not pay the invoice until the claims are removed and a new invoice submitted. If the invoice total dollar amount does not match the sum of the individual details on the claims tape, the plan would not pay the invoice until charges are reconciled.
- As a self-funded plan, negotiate provider access fees and administration charges as per contract (or per covered life) amounts to more accurately reflect actual utilization.

Eligibility

The system should maintain its own eligibility database, interface with MPSERS' eligibility and enrollment system for school district employees, and manage eligibility records on spouses and dependents. There should be a common definition of coverage, with daily feeds of eligibility changes to the various health plans. As a self-funded plan, the plan's costs can be controlled by effective eligibility management. Best practices eligibility management would include the following procedures:

- Daily eligibility updates should be sent to carriers. Carriers would then be held financially accountable for services provided to ineligible members after a 48-hour grace period.
- Spousal eligibility should be determined only after the plan receives positive certification of marriage.
- Dependent eligibility should be determined upon receipt of a birth certificate or proof of adoption, as applicable.
- Student eligibility should be re-determined twice a year. Parental confirmation of the student's full-time status at a named college at the beginning of the college year, and continued eligibility would only be provided upon receipt of confirmation from the student's college or university in January.

Coordination of Benefits

As a self-funded plan, it would be cost-effective to employ specialized staff to supplement the efforts of the claims administrator's COB staff and conduct research on Medicare Secondary Payer notices as well as subrogation for Workers' Compensation and non-auto claims. While BCBSM employs a large staff that administers COB, MESSA found that it was beneficial to administer this function internally.

Carve-outs

An effective cost management approach that has been implemented by large employer groups is to “carve-out” specific benefits from the health plan and separately negotiate the coverage. The most common benefits that are managed through a carve-out arrangement are:

- Prescription drugs
- Mental health and substance abuse
- Durable medical equipment
- Chiropractic care
- Transplants

Of these possible carve-out benefits, prescription drugs represent the largest portion of benefit costs. Pooling all the pharmacy claims into a single contract has several advantages. First, it ensures benefit comparability across all medical delivery systems. Second, it facilitates ease of communication to members with the introduction of new drugs and changes in generic status. Third, it makes it possible for the plan to periodically negotiate with national pharmacy benefit managers and obtain the best possible price and service arrangements. Currently, fewer than 15 percent of the school employees have carved-out prescription drug benefits.

Similarly, carving out the mental health and substance abuse benefits and contracting with a national (or state-wide) firm specializing in this care can improve care and significantly lower costs.

The plan's size will also enable it to write contracts with durable medical equipment providers on very favorable terms.

Disease Management

Emerging best practices have shown that adding resources for employees and dependents with chronic diseases, to help them manage their health, can result in improved outcomes and cost savings that more than offset the cost of the additional resources. Disease management program outcomes include a slowing down of disease progression, reduction in hospitalization, less frequent use of emergency rooms and fewer urgent doctor visits, as well as a reduction in work days missed. Currently, insurers that have disease management programs usually target those individuals whose prior claim histories indicates that they have health problems (or health risk

factors indicating impending health problems) that can be improved or mitigated by disease management. School district employees can be expected to remain covered for life: either by the active school employees' health plan or by the retired school employees' health plan. Therefore a state-wide health care system's disease management program could be expanded to cover both high and low severity individuals, with the expectation that the mitigation of health problems will not only reduce lifetime health care costs, but equally importantly, it will improve and prolong the life of covered individuals.

A self-funded plan could analyze the population data on prevalence of diseases among the covered employees and use that information to identify and implement programs that would be both cost-effective and broadly used.

Cost Reduction Opportunities

Combining all of the above cost reduction opportunities, we estimate that a system-wide health plan could achieve the following levels of savings in its initial year of operation.

Option 1	6.71 percent
Option 2	8.95 percent
Option 3	9.75 percent

These savings were developed from the following elements. A description of the development of these savings can be found in Appendix C.

TABLE 4.1			
	Option 1	Option 2	Option 3
Eligibility Management <ul style="list-style-type: none">• Frequent updates• Student eligibility	0.65% <u>0.14%</u> 0.79%	0.65% <u>0.14%</u> 0.79%	0.65% <u>0.14%</u> 0.79%
Self Funding <ul style="list-style-type: none">• Insurer Gain• Stop-loss premiums• Commissions• Subsidies	1.54% 0.17% 0.16% <u>0.77%</u> 2.64%	1.54% 0.17% 0.16% <u>0.77%</u> 2.64%	1.54% 0.17% 0.16% <u>0.77%</u> 2.64%
Purchasing <ul style="list-style-type: none">• Negotiated admin fees• Provider access fees• Pharmacy carve-out• DME carve-out• Audits	0.11% 0.63% 2.24% 0.20% <u>0.10%</u> 3.28%	1.22% 0.65% 3.35% 0.20% <u>0.10%</u> 5.52%	1.23% 1.43% 3.36% 0.20% <u>0.10%</u> 6.32%
Total	6.71%	8.95%	9.75%

Assuming no other changes in the Michigan system, when fully implemented these savings from self-funding and centralized administration would reduce aggregate system spending to the following levels.

TABLE 4.2		
Total Expected Healthcare Expenditure Under a State-wide System		
FY2005/06 – Option 1		
	Enrollment	Annual Premium
Schools <100 enrollees	39,661	\$439,911,256
Schools >100 enrollees	142,092	1,494,651,697
Total For Schools	181,753	\$1,934,562,953
Community Colleges	8,756	84,773,670
Grand Total	190,509	\$2,019,336,623

V. ALTERNATIVE APPROACHES

A. Alternative Structures for State-wide Health Care Plans

This chapter reports on alternative structures for five different aspects of a potential state-wide health plan for Michigan school district employees. These are:

- Benefit design
- Whether the plan should be voluntary or mandatory
- How the plan should be governed
- How the plans should be administered
- How the change in cost is allocated

B. Benefit Design

Savings in a state-wide system could be achieved primarily in four areas. These are savings through changes in funding, administration benefit design, and the delivery system. We discuss the potential savings for each of these changes in this section. Details of the calculations of each savings are included in Appendix C.

One alternative would be to provide the current benefit plan design to all school district employees their dependents. This approach would limit in the direct administrative savings available because the state-wide plan would have to offer and administer a very wide range of benefit designs. However, analysis of this alternative permits us to isolate the savings attributable to benefit design changes, compared to cost savings attributable to other factors.

The primary source of savings for this alternative would be through the transition to self-funding and changes in administration. These are of two types. The first type is direct reduction in non-claim costs paid to health plans, such as insurance company reserves. The second is through more efficient administration that would be available in a unified state-wide system, such as improved eligibility and coordination of benefits.

Table 5.1 shows the breakdown of the premium for the current system and the premium that would have been paid if the same benefits were administered through a state-wide system.

Table 5.1			
Total Expected Healthcare Expenditure under a Statewide System			
FY2005/06 – Option 1			
	Enrollment	Current Annual Costs	Annual Costs after the Change
Schools <100 enrollees	39,661	\$471,552,424	\$439,911,256
Schools >100 enrollees	142,092	1,602,156,391	1,494,651,697
Total For Schools	181,753	\$2,073,708,814	\$1,934,562,953
Community Colleges	8,756	90,871,122	84,773,670
Grand Total	190,509	\$2,164,579,936	\$2,019,336,623

A second alternative would be to provide benefits through a state-wide system that encompass most of the benefits currently offered by the school districts. Table 5.2 shows the design of the options that would be offered through a state-wide system with HMOs and five plan choices: high and low option fee-for-service plans, high and low option PPOs, and a POS plan. Table 5.3 shows the premium that would be paid through a state-wide system that offers the benefits shown in Table 5.2.

The analysis of the second alternative requires us to model – based on current benefits and cost levels – which of the plans offered through the state-wide system each district would likely select. We slotted plans using the following selection process:

- If the current employer cost is higher than the cost of the highest value state-wide plan, the employees would be placed in the highest value state-wide plans.
- If the current employer cost is between the cost of the lowest value and highest value state-wide plan, the employees would be placed in:

The highest value state-wide plan if the current plan value is higher than the value of the lowest value state-wide plan.

The lowest value state-wide plan if the current plan value is lower than the value of the lowest value state-wide plan.

- If the current employer cost is lower than that of the lowest value state-wide plan, the employees would be placed in the lowest value state-wide plan.

The state-wide plan would provide optional dental and vision benefits. Initially school districts could elect these options or select dental and vision coverage from some other source. This would permit organizations currently providing dental and vision plans to continue to offer these plans to school districts.

A state-wide health plan can make decisions and implement changes that affect all employees equally and immediately. Our opinion is that there are several areas in which a state-wide plan can act to reduce costs while limiting the impact on the employees. These include:

1. Use the plan's large enrollment and purchasing power to negotiate favorable terms
2. Carving out and separately contracting for specific services, including pharmacy benefits, MHSA benefits and durable medical equipment.
3. Targeting additional resources for employees and dependents with chronic conditions as well as wellness initiatives.

In addition the state-wide plan could include options with Health Reimbursement Accounts and/or Health Savings Accounts. These would be high-deductible plans coupled with direct state contributions that would not increase the overall cost of the system.

TABLE 5.2					
Description of Plan Options					
	Fee-for-Service Plans		Preferred Provider Organization Plans		Point of Service Plan
Type of Care	High Option	Low Option	High Option	Low Option	In-network Benefits
Plan Deductible	\$50	\$100	\$0	\$0	\$0
Maximum Out-of-Pocket Limit	\$1,000	\$1,000	\$0	\$0	\$0
	Co-payments / Coinsurance				
Inpatient hospital	100%	100%	100%	100%	100%
Surgical	100%	100%	100%	100%	100%
Physician Visits	100%	90%	\$5 copay	\$10 copay	\$20 copay
Specialty Visits	100%	90%	\$5 copay	\$10 copay	\$20 copay
Mental Health and Substance Abuse Treatment – Inpatient	100%	100%	100%	90%	100% up to 45 days
Mental Health and Substance Abuse Treatment – Outpatient	90% up to 50 visits	90% up to 50 visits	\$5 copay	90% up to 65 visits	100%
Preventive Services	100%	100%	\$5 copay	100%	\$20 copay
	Prescription Drug Coverage				
Coverage for Generic	\$2 copay	\$10 copay	\$5 copay	\$10 copay	\$10 copay
Coverage for Preferred	\$2 copay	\$20 copay	\$10 copay	\$10 copay	\$15 copay
Coverage for Non-preferred	\$5 copay	\$20 copay	\$10 copay	\$10 copay	\$20 copay

Table 5.3 shows the resulting cost of the state-wide plan with the five standard plans.

TABLE 5.3			
Total Healthcare Expenditure with Five Standard Plans			
FY2005/06 – Option 2			
	Enrollment	Current Annual Costs	Annual Costs after the Change
Schools <100 enrollees	39,661	\$471,552,424	\$438,823,491
Schools >100 enrollees	142,092	1,602,156,391	1,486,374,984
Total For Schools	181,753	\$2,073,708,814	\$1,925,198,475
Community Colleges	8,756	90,871,122	84,363,313
Grand Total	190,509	\$2,164,579,936	\$2,009,561,788

Table 5.4 shows the number of employees who would receive a higher benefit and the number who would receive a lower benefit in the state-wide plan compared to their current plan. The selection of options, and the comparison used in developing tables 5.3 and 5.4 was the BVC method described in Appendix C. Employees in HMOs are assumed to remain in HMOs.

TABLE 5.4	
Winners and Losers with Five Standard Plans	
Option 2	
Change in Benefit from Current Level	Percent
Decrease in benefits of more than 10%	0.3%
Decrease of 5% to 10%	8.3%
Decrease of less than 5%	0.8%
No Change	44.2%
Increase of less than 5%	44.5%
Increase of 5% to 10%	1.5%
Increase of more than 10%	0.5%
Total	100.0%

A third option for the state-wide plan would be to remove the FFS plans. Most large employers have shifted from the traditional FFS approach that permits employees to select any physicians or hospitals without restriction or penalties for going to an out-of-network provider. The opposite approach, used by HMOs and POS plans, has been to restrict access to the health care system to those providers approved by a primary care physician (*i.e.*, a gatekeeper). The POS approach has proven unpopular with many employees. However, the PPO approach is one that

reduces unnecessary cost while giving the employee access to the health care system without a gatekeeper. We think it would be reasonable for a state-wide plan to move away from the FFS approach. For the purposes of this analysis we have shifted the high-option FFS employees to the high-option PPO and the low-option FFS to the low-option PPO.

TABLE 5.5			
Total Healthcare Expenditure after elimination of FFS Plans			
FY2005/06 – Option 3			
	Enrollment	Current Annual Costs	Annual Costs after the Change
Schools <100 enrollees	39,661	\$471,552,424	\$405,868,864
Schools >100 enrollees	142,092	1,602,156,391	1,398,941,340
Total For Schools	181,753	\$2,073,708,814	\$1,804,810,204
Community Colleges	8,756	90,871,122	79,087,829
Grand Total	190,509	\$2,164,579,936	\$1,883,898,033

Table 5.6 shows the number of employees who would receive a higher benefit and the number who would receive a lower benefit in the state-wide plan compared to their current plan. The reduced cost produced by the use of PPO networks allows for reduced employee cost-sharing without increasing program costs. As a result, fewer school employees would see a reduction in benefits under option 3, and more would see increased benefit levels.

TABLE 5.6	
Winners and Losers	
Option 3	
Change in Benefit from Current Level	Percent
Decrease in benefits of more than 10%	0.1%
Decrease of 5% to 10%	7.2%
Decrease of less than 5%	1.2%
No Change	17.6%
Increase of less than 5%	45.5%
Increase of 5% to 10%	27.9%
Increase of more than 10%	0.5%
Total	100.0%

Table 5.7 below summarizes the sources of savings for each of the three options.

TABLE 5.7			
Sources of Savings Under a State-wide Plan			
FY2005/06 (Dollars in Millions)			
	Option 1	Option 2	Option 3
Single Self-Funded System	\$57	\$57	\$57
Centralized Administration	\$89	\$137	\$155
Move to Standard Plans	\$0	(\$39)	(\$39)
Elimination of FFS Plans	\$0	\$0	\$108
Total Savings	\$146	\$155	\$281

C. Voluntary or Mandatory Participation

A key issue in a state-wide plan is whether to mandate that all school districts join the plan or let the school districts participate on a voluntary basis.

If the plan were mandatory, it would be necessary to amend the Public Employment Relations Act (PERA) to exempt from collective bargaining the bargaining parties' right to select health care plans. PERA could, however, give the bargaining parties the ability to negotiate: the effective date of participation in the state-wide plan (within certain parameters), which plan options would be available to bargaining unit employees, the cost-sharing arrangement, and other matters to the extent there is flexibility offered in the authorizing statute and the state-wide system. With respect to the effective date of a school district's participation in a state-wide plan, we recommend that the statute provide for transition to the state-wide system the later of (a) three years or (b) the expiration of collective bargaining agreements in effect as of the authorizing statute's effective date. This would give bargaining parties time to prepare for the transition and renegotiate benefits and contributions as appropriate to reflect any changes in the benefits and premiums available to the school district under the new system.

A mandatory plan would probably achieve higher savings than a voluntary plan. However, those savings would not be substantially higher than the savings for a voluntary plan if all employers chose the most economically effective approach in providing the benefits. For instance, some school districts in Michigan have a lower cost group than the average cost for all school districts in Michigan. If one of those school districts were to stay outside the state-wide system then the total cost for all school systems would not change. However, the cost paid by all other school districts would be somewhat greater.

The following tables project the cost savings in the first five years of operation for option 3 under both a mandatory and voluntary approach. The projections include the start-up funding that would be needed by MPSERS or a new organization. We estimate that the start-up funding would be \$3,000,000 with half of the funds required in the year before implementation of the

new system. Therefore, table 5.8 shows an additional \$1,500,000 cost in the year ending June 30, 2005 with no offsetting savings in that year.

TABLE 5.8	
Option 3 Mandatory Plan starting July 2006 (School FY 2006/07)	
Year	Total Savings
2005	\$ (1,500,000)
2006	192,533,841
2007	349,903,597
2008	400,235,737
2009	\$ 422,108,480

TABLE 5.9	
Option 3 Voluntary Plan starting July 2006 (School FY 2006/07)	
Year	Total Savings
2005	\$ (1,500,000)
2006	115,266,766
2007	236,246,539
2008	316,621,109
2009	\$ 349,863,252

D. Governance

Another important aspect of a state-wide system would be the method by which changes would be made. This, in turn, depends largely on the membership of the governing board of the system.

Michigan Senate Bill 55 had specified a governing board that would be appointed by the governor. We understand that the governance system in Senate Bill 55 was not meant to limit options we examine. We considered two alternatives for the governing board and decision making process:

- A board similar to that of MPSERS.
- A board with equal representation of management and unions.

A board similar to MPSERS would have representatives of each group of stake-holders appointed by the Governor. These would include representatives of management, active and retired school employees, and representatives of the public. The board would probably establish procedures similar to MPSERS in considering plan changes. However, the changes would not be subject to collective bargaining at the school district level.

The other construction would be limited to representatives of management and labor. There would be no representatives of the state or the public. This structure would be most like that used in a Taft-Hartley plan, where, under Federal law governing private sector employers, employee benefit plans are managed jointly by equal numbers of union and management representatives. Taft-Hartley health and welfare plans have been highly successful.

E. Administration

There are a number of alternatives for the administrative structure of a state-wide plan. Two existing structures are possibilities. These are:

- Add the administrative duties to MPSERS
- Add the administrative duties to Civil Service

Another alternative would be to set up a new administrative operation.

Use of an existing administrative structure would permit the plan to begin operations by the school district 2006/2007 plan year. The cost analysis shown above assumes that initial operation date would be July 1, 2006. The initial system would cover at least the school districts with collective bargaining agreements that will expire in the next year. We assumed that the other school districts would be added as their current collective bargaining agreements expire.

We believe that the MPSERS health plan that currently covers retired school employees could be expanded to cover active school district employees. MPSERS already has a strong working relationship with all school districts, including procedures in place to receive contributions. MPSERS also has strong experience working with school district employees, and is in a good position to expand that knowledge to the needs of active school district employees.

The board governing the design of the benefits for the active school employees would probably be somewhat different in composition from the current MPSERS board. For example, the board would probably not include a representative of the retired school employees. However, many of the other members might be the same or have similar credentials.

We do not believe that it would be appropriate or feasible to expand the Civil Service health benefits system to include school employees. The Civil Service health benefit system is tied directly to the state as the employer of all Civil Service employees, and including school district employees would radically change the effective operation of the Civil Service plan and radically alter the focus of the Civil Service program by virtue of the fact that there are almost four times as many school district employees as Civil Service employees. Lastly, the Civil Service staff

have little, if any, experience working with school district employees, who have different backgrounds, training, and experience.

Although it would be possible to create an entirely new entity to administer a state-wide health program for school district employees, we believe that a totally new administrative operation would delay the implementation of the state-wide plan by a year. This would defer savings. Also, creating a new entity has inherent start-up problems that are difficult to anticipate.

F. Financing

The school district health plans are currently financed, in large part, by the school districts. However, a large portion of the financing indirectly comes from state financing of the school districts. State funds are not earmarked for either total compensation or health benefits but, in effect, a large portion of health care benefits is funded by the State of Michigan.

The first alternative assumes no change in the benefits offered to employees. Assuming no change in premium rating methods, this would provide school employees with the same benefits at a reduced cost.

The second and third alternatives would result in a lower cost for the health insurance for most school districts and a higher cost for some school districts. The school districts and employee representatives would determine the extent to which the savings or cost increase would be shared by the school district and the employees as part of the collective bargaining process.

Our modeling assumes that school districts would continue to bargain specific benefit packages. The system we propose could allow each school employee to choose from among all of the plans offered through the proposed system (subject to limitations on HMO service areas), with employee contributions structured to encourage employees to migrate into less expensive plans. This extending this option to school employees should be considered as part of the implementation process, and adopted if there is no adverse cost impact. Our modeling does not reflect any additional savings that might be gained through this approach.

Almost all of the school districts are charged premiums that reflect regional rating. Most small plans are being charged regional rates by MESSA or BCBSM. Many of the larger plans are being experience-rated so, in effect, they are being charged the higher or lower cost associated with their region. Our modeling assumes that the proposed system would use a single, state-wide set of premium rates. Adopting a regional rating system has the potential to reduce the number of school employees who would see increased costs (or reductions in benefits). This should also be considered as part of the implementation process.

VI. IMPLEMENTATION ISSUES

If the State of Michigan were to mandate that all school districts be required to participate in a single state-wide health plan, we recommend that the school districts be permitted to phase into the Plan not later than upon the expiration of their current collective bargaining agreements. If the Plan rates and benefits were attractive enough, some labor and management groups might reopen contract negotiations to permit early transition into the state-wide Plan.

The State could preempt the collective bargaining process and enact a law that would require all school districts to participate in a state-wide plan by some specific date, without regard to the desires of the bargaining parties. However, for political and practical reasons we recommend that any mandatory participation or similar types of change be phased in, by requiring transition to the state-wide system by the later of: (a) three years, or (b) the expiration of the collective bargaining agreement in effect as of the effective date of the authorizing statute. A gradual transition will permit a more orderly start-up of the state-wide plan. However, the state-wide savings that could be realized would not be fully achieved until the expiration of all agreements. Table 6.1 shows the year of expiration of collective bargaining agreements in our survey.

TABLE 6.1	
Year of Expiration of Collective Bargaining Agreements	
Year of Expiration	Number of Collective Bargaining Agreements
2005	115
2006	72
2007	30
2008	3
2009	1
Open	30
Grand Total	251

In some cases, it may not be possible to terminate the existing health plan contract without significant penalties. For example, there may be an experience rating deficit for the plan that the insurer would have recovered through additional charges if the plan had continued past the end of the existing collective bargaining agreement. Therefore, the law might allow some additional time to shut-down existing arrangements past the end of the collective bargaining agreement in unusual circumstances.

If the state-wide plan were to be voluntary, then there would not have to be any participation deadlines, since each school district could choose to participate, or decline to participate on a time schedule that best meets its current health insurance and their current collective bargaining

arrangements. A secondary issue in a voluntary arrangement is to what extent, if any, school districts may leave the state-wide plan and later return. Our review of other states with voluntary participation indicate a range of answers from not permitting school districts to opt out, to requiring a minimum exclusion period such as three years, to unlimited ability to leave and return to the state-wide plan.

A. Implementation Steps

The first step would be to develop legislation implementing the state-wide plan. The legislation should establish the administrative structure necessary to implement the plan and contain other authority necessary to the successful implementation of the plan. If, for instance, participation were mandatory, the legislation would need to include the conditions under which school districts would have to join the plan (such as the conditions under which the school districts could and would be required to join the plan, the levels of benefits to be offered, and the administrative structure). We recommend that the legislation be silent on exact specifications of the plan such as deductibles, co-payments, or types of plans that would have to be covered. Health insurance and delivery systems are very dynamic and the best practices today, *e.g.*, negotiation through PBMs for prescription drugs, could well change to a neutral or even detrimental requirement in the future. The Federal Employees Health Benefits Program has successfully met arising challenges for almost a half century because the requirements of the legislation are very broad.

We recommend that the state-wide system be administered by either MPSERS or a new state agency. Based on our review of MPSERS we believe that its operations could be expanded to cover school district employees as well as retirees. We do not think that the health plan for state employees should be expanded to include school district employees because of the different funding mechanisms, the inherent differences in the populations, differences in the health care needs of each population, and the differences in customer service needs.

The other alternative would be to establish a new state agency. The advantage would be that the new agency would focus directly on the health care for employees rather than retirees. The primary disadvantage is that we believe an entirely new organization would delay implementation of the state-wide system by at least a year.

After passage of the legislation, the organization responsible for implementation (MPSERS, or a new state agency) will study how best to implement the legislation on a timely basis. This consideration will include the following:

- How best to contract with school districts to provide the health insurance to their employees.
- When and how to enroll eligible employees and permit changes after the first enrollment.
- The most effective approach for contracting with health-care providers and insurers to deliver the best benefits at the lowest possible cost.
- The organizational changes needed to implement the new state-wide plan including staffing, space, and computer systems.

- How to determine and charge the premiums paid by the school districts employees.
- The range of choices of health plan and the design of each of the choices.

The administrating organization would then prepare a timetable for implementation. The timetable should conform to any requirements in the enabling legislation.

The administrating organization would then negotiate agreements with the school districts that would be required to, or chose to, participate in the first year of the plan. These agreements would include the employees to be covered, the options selected by the school district, and the financial arrangements between the organization and the school district. The administrator would determine the date of entry of each school district into the state-wide plan based on provisions in the law and such considerations as collective bargaining and the financial position with current health insurer.

The administrating organization would negotiate coverage with health care providers and insurers throughout the State of Michigan and also contract with a national network to provide coverage for employees traveling outside Michigan. The goal of the negotiations would be to provide the best health care to individuals at the lowest price with the health care providers and insurers.

The administrating organization would then prepare the description of the plans available to employees in each school district and distribute that information to the individuals in sufficient time to make an educated choice of health plan for the first year.

The administrator would provide a system for the potential enrollees to make a timely decision on choice of health plan. The system would be the data base used to (1) prepare bills for school districts, (2) confirm enrollment for coverage, and (3) confirm eligibility for claims payments.

During the design period, the administrator would have put into place the organization needed to effectively administer the program. A large part of this organization would have to be in place well before the first enrollment date. The organization would have to include at a minimum:

- An enrollment verification and processing division.
- A claims administration division.
- A division to monitor and audit the contracts with the health care providers and insurers.
- A call center to handle calls from enrollees, school districts, and providers.
- An executive director's office to manage the system.

B. Implementation Timetable

Since the state-wide plan would require enabling legislation we believe that the earliest effective date would be July 1, 2006. The most rapid timetable for implementation using the MPSERS as administrator is set forth below.

TABLE 6.2	
Implementation Schedule if Administered by MPSERS	
Time Frame	Activity
August – September 2005	Enter into discussions with MPSERS regarding the feasibility of administrative services sharing agreement.
August 2005 – September 2005	Governor develops budget details and administrative proposal, develops fiscal impact study and other supporting reports and materials, discusses proposal with stakeholders and adjusts proposals as necessary.
October 2005	Enabling Legislation introduced.
November 2005	Enabling Legislation passed.
October – December 2005	MPSERS conducts study of plan design and premium structure and initiates contracts for administrative and other support services.
February 2006	Governor introduces FY 2006-07 budget and legislative initiative with costs and benefits enumerated.
January - March 2006	Contract revisions with health care providers begins. Administrative structure developed for launch of program.
March – April 2006	School districts and other interested parties notified of changes, effective July 1, 2006. Information materials and enrollment materials developed. Timetables for enrollment sessions developed. Termination notices given to current carriers as soon as necessary.
May - June 2006	Open Enrollment Period: School districts distribute information and enrollment materials to their employees. Employee election forms returned by June 15, 2006.
July 1, 2006	New plan effective for first group of school districts.

Implementation would take significantly longer if a new agency were to be the administrator. A new agency would require extensive start-up time. The administering agency would have to add a major new operation which would probably require almost as much time as a new agency. Table 6.3 shows the expected time line if a new agency were to administer the state-wide plan.

TABLE 6.3	
Implementation Schedule if Administered by New Agency	
Time Frame	Activity
August 2005 – September 2005	Governor develops budget details and Administrative proposal, develops fiscal impact study and other supporting reports and materials, discusses proposal with stakeholders and adjusts proposals as necessary.
October 2005	Enabling Legislation introduced.
November 2005	Enabling Legislation passed.
November, 2005 – December 2006	New agency organized
February 2006	Governor introduces FY 2006-07 budget and legislative initiative with costs and benefits identified.
October 2006 – February 2007	Agency conducts study of plan design and premium structure and initiates contracts for administrative and other support services.
February 2007	Governor introduces FY 2007-08 budget with operating costs identified.
January - April 2007	Contract negotiation with health care providers begins. Administrative structure developed for launch of program.
February – March 2007	School districts and other interested parties notified of changes, effective July 1, 2007. Information materials and enrollment materials developed. Timetables for enrollment sessions developed. Termination notices given to current carriers as soon as necessary.
April - May 2007	Open Enrollment Period: School districts distribute information and enrollment materials to their employees. Employee election forms returned by May 15, 2007.
July 1, 2007	New plan effective for first group of school districts.

C. Cost Impact of Implementation

The timing of the full realization of the savings available from consolidation would depend on three factors: whether the plan is mandatory or voluntary for school districts, how quickly the new plan could be implemented, and when individual school districts join the plan.

We believe that the state-wide plan could begin to operate as early as July 2006 if it is administered by MPSERS. We assume that even a mandatory plan would not require participation by school districts until their current collective bargaining agreements expire.

TABLE 6.4		
Option 3		
	Mandatory Plan starting July 2006 (School FY 06/07)	Mandatory Plan starting July 2007 (School FY 07/08)
Year	Total Savings	Total Savings
FY2005/06	\$ (1,500,000)	
FY2006/07	\$ 192,533,841	\$ (1,530,000)
FY2007/08	\$ 349,903,597	263,375,610
FY2008/09	\$ 400,235,737	398,894,387
FY2009/10	\$ 422,108,480	\$ 422,108,480

These projections are based on the expiration dates of the current collective bargaining agreements covering school employees. The total savings available on a fully-implemented basis are allocated to those schools with bargaining agreements expiring in 2005, those with bargaining agreements expiring in 2006, etc. For each school district fiscal year, we project the cumulative percentage of total savings attributable to school districts with collective bargaining agreements that will have been renegotiated prior to the beginning of that fiscal year. Premiums and savings are adjusted to reflect the assumed health care cost trend rates shown in table 6.5.

We assume that implementation of a state-wide system will require the investment of \$1.5 million in direct spending by the plan administrator (either MPSERS or a new agency) in the six to twelve months prior to the first plan year. In other words, if coverage is first provided effective for the school district fiscal year 2006-07 beginning on July 1, 2006, then there will \$1.5 million will spent during the school district fiscal year 2005-2006. We assume the same level of direct administrative spending for the first full year of implementation. After that, direct spending by the plan administrator should drop to approximately \$0.25 million per year. These expense assumptions are expressed in current dollars; the projection assumes a 2 percent annual inflationary increase in administrative expenses.

To ensure the stability of the system, we recommend the establishment of a contingency fund equal to 4 percent of projected annual program spending. The establishment of this fund reduces the savings available in the first two years, as the number of participating districts grows rapidly. The projected impact is much less for subsequent years. Once the initial contingency fund is established, the annual fund increases necessary to keep pace with health care costs will be comparatively modest. We have not incorporated investment earnings on the fund into our projections, but they should provide a partial offset against these costs.

VII. RECOMMENDED APPROACH

The State of Michigan funds the majority of school employees health care costs, albeit indirectly, through the current structure of payments to school districts. School employees participate in a single state-wide pension plan, and all former employees receiving retirement benefits from MPSERS are eligible to participate in the MPSERS health plans. Our recommended approach builds on these commonalities within a framework that provides financial relief to the school districts and/or the State.

Our recommended approach would be to provide a state-wide system to provide health benefits to school employees administered by MPSERS. School districts would be required to join the state-wide system at the conclusion of their current collective bargaining agreements. The system would offer the following choices of plans:

- Two PPO plans
- One POS plan
- HMOs that serve the employee's locale

Health benefits would continue to be the subject of local bargaining contracts, with a broad range of choices on how school employees can access healthcare services from PPO, POS, and HMO plans. Almost all large employers have moved away from traditional FFS plans because of the high cost of unlimited access to the health care system. These employers have also taken advantage of the many opportunities to reduce prescription drug costs. We believe that these steps should be taken.

Table 7.1 projects the expected savings resulting from the state-wide system. The expected savings in the first year of operations from implementing the recommended approach is \$192 million. Much of the savings comes from reduced administrative expenses as well as more effective administration. The rest of the savings comes from changes in the level and delivery of benefits. The annual savings from our recommended approach would increase each year as more school districts join the plan. In the fourth year of operations the savings would be \$422 million.

TABLE 7.1	
Recommended Approach Mandatory Plan starting July 2006 (School FY 2006/07)	
Year	Total Savings
FY2005/06	\$ (1,500,000)
FY2006/07	192,533,841
FY2007/08	349,903,597
FY2008/09	400,235,737
FY2009/10	422,108,480

We recommend that the system be mandatory, at least for the smaller school districts. Should the system be voluntary for the larger school districts, savings from operating a state-wide system will result in lower premium rates providing a financial incentive for many larger school districts to participate. If participation is made voluntary for larger districts, we recommend that the ability to opt-out be limited to those districts that are large enough to self-insure and aggressively manage their health benefit programs.

The recommended approach will reduce benefits for fewer than 10 percent of Michigan school employees. Many school employees would see a significant increase in the value of their benefits as shown in Table 7.2. About half of the school employees would have to move from a FFS plan, with unrestricted choice of providers, to a PPO or POS plan.

TABLE 7.2	
Winners and Losers Recommended Approach	
Change in Benefit from Current Level	Percent
Decrease in benefits of more than 10%	0.1%
Decrease of 5% to 10%	7.2%
Decrease of less than 5%	1.2%
No Change	17.6%
Increase of less than 5%	45.5%
Increase of 5% to 10%	27.9%
Increase of more than 10%	0.5%
Total	100.0%

GLOSSARY OF KEY TERMS

Adverse Selection (Anti-Selection)

The tendency of individuals with a higher probability of incurring claims (high risk) to select the maximum amount of insurance protection, while those with lower probability elect lower levels of, or defer, coverage.

Administrative Services Contract (ASC)

A contract offered by Blue Cross Blue Shield of Michigan to provide self-funded benefits to an employer or other plan sponsor. (See Administrative Services Only Contract.)

Administrative Services Only (ASO) Contract

Contract with an insurance company or health plan to provide self-funded benefits to an employer or other plan sponsor. An ASO contract is not an insurance policy, because the health plan does not take any insurance risk, but only administers benefits funded by the health plan sponsor. In this case, the health plan administrator takes the role of a third-party administrator (TPA).

AEPC

AFL-CIO Employer Purchasing Coalition.

BCBSM

Blue Cross Blue Shield of Michigan.

Carve-Out

Removing a specific benefit from the contract with the primary health plan and negotiating the coverage separately, usually with a specialty vendor or network. For instance, prescription drug coverage is often purchased separately on a self-funded basis from a specialized pharmacy benefit manager.

Case Management

A process which focuses on coordinating a number of services required by severely ill or injured participants to ensure that provided services are appropriate, timely, thorough yet non-redundant and cost effective.

Centers of Excellence (COE)

Medical facilities that contract with a health plan to provide medical care for specific types of high cost services, such as transplants or cancer treatment. Centers of excellence are selected based on outcomes and cost effectiveness, and typically perform a large number of procedures with highly favorable outcomes and low incidents of adverse results.

Coinsurance

A common provision of healthcare plans in which the covered individual and the insurer or plan sponsor share in a specified ratio of health care expenses (*e.g.*, 80% paid by plan, 20% paid by participant). In a PPO or POS plan, the ratio usually favors the covered individual when the costs are incurred with providers who are part of the PPO or part of a specified network (*e.g.*, 100% coverage within the PPO or network and 70% coinsurance ratio for providers outside the PPO or network).

Contributory Benefit Plan

A program in which the employee contributes part (or all) of the cost, and any remainder is covered by the employer.

Coordination of Benefits (COB)

A provision of a group health plan that eliminates duplicate payments from multiple carriers and prevents an employee from collecting more than 100 percent of the charges for the same medical expense. The provision also designates the sequence in which primary and secondary coverage will be paid when an individual is covered under two plans.

Co-Payments

Payments which are required to be made by covered participants on a per service basis (*e.g.*; \$20 co-pay per physician visit). Co-payments are commonly used to discourage inappropriate utilization and to help finance healthcare plans.

Deductible

The amount paid by an employee for covered expenses in a group health plan before the plan pays benefits. A typical plan would follow a calendar year schedule and specify an individual deductible and a higher family deductible.

Disease Management (DM)

The process of identifying health plan enrollees with particular health conditions or risk factors, then assisting those enrollees in managing their conditions to delay the onset or slow the progression of disease.

Durable Medical Equipment (DME)

Medical equipment, such as a hospital bed, wheelchair, or oxygen equipment that may be prescribed by a physician and that has an extended useful life.

Experience Rating

A premium based on the anticipated claims experience of, or utilization of service, by a contract group according to its age, sex, and any other attributes expected to affect its health service utilization. Such a premium is subject to periodic adjustment, generally on an annual basis, in line with actual claims or utilization experience.

Fee-for-Service Plan (FFS)

A traditional plan which provides for each reimbursement for designated covered healthcare services on a fee-for-service basis, with no provider network or negotiated discounts.

Formulary

A list of preferred medications within a prescription drug plan that have been chosen by the pharmacy benefits manager (PBM). Typically, formularies are developed to steer plan participants (through lower co-pays) and their physicians to cost effective or discounted drug alternatives.

Gatekeeper

Usually a primary care physician, who is responsible for directing the patient's care. To receive full benefits, participants must be referred to other medical specialists by their gatekeeper physician. This type of physician generally is found in HMOs and Point-of-Service (POS) networks.

Health Maintenance Organization (HMO)

A pre-paid medical group practice plan that provides a comprehensive predetermined medical care benefit. In order for an individual's healthcare costs to be paid, the individual must utilize services from the specified HMO network of providers. A participant's care is monitored and controlled by a selected primary care physician who is accountable for the total health services of the participant, arranges referrals and supervises other care, such as specialist services and hospitalization.

Health Reimbursement Account (HRA)

A tax free employer funded account that provides employees with medical care expense reimbursements. These accounts allow unused funds within the account to be carried forward to future years. HRAs are typically provided with high deductible medical plans.

Health Risk Appraisal

A method of appraising the health status of a plan participant, generally via a health questionnaire and basic health measurements.

Health Savings Account (HSA)

A pre-tax account that is funded by employees and/or employers to cover employees' out-of-pocket expenses. These accounts require an employee to be enrolled in a qualified high deductible plan. Unused funds in the HSA may be carried forward to future years.

Indemnity Plan

A traditional plan which provides for each reimbursement for designated covered healthcare services on a fee-for-service basis, with no provider network or negotiated discounts.

Managed Care

Control of utilization, costs, quality and claims, using a variety of cost containment methods, including pre-certification and case management. The primary goal is to deliver cost-effective healthcare without sacrificing quality or access.

MASA

Michigan Association of School Administrators.

MASB

Michigan Association of School Boards.

Maximum Benefit

The maximum amount that a health care plan will pay on behalf of a covered participant during that individual's lifetime.

MEA

Michigan Education Association.

MEBS

Michigan Employee Benefit Services, Inc.

MESSA

Michigan Education Special Services Association.

MFT

Michigan Federation of Teachers & School Related Personnel.

MPSERS

Michigan Public School Employees Retirement System.

MSBO

Michigan School Business Officials.

National Committee for Quality Assurance (NCQA)

A non-profit organization that accredits managed care organizations. The accrediting process evaluates organizations against a specific set of standards.

Out-of-Pocket Limit

The maximum amount of out-of-pocket healthcare expenses that a participant is responsible for during a plan year. Every dollar spent on healthcare after this amount is generally reimbursed in full.

Pharmacy Benefit Manager (PBM)

An organization that administers prescription drug benefits. PBMs can be stand alone organizations or part of the carrier that handles the medical benefits. Typically, PBMs negotiate deeper prescription drug discounts, use lists of preferred drugs called a "formulary," and coordinate and monitor patients' prescription drug utilization thus reducing dangerous drug interactions and in other ways enhancing patient care.

Precertification/Predetermination

An administrative procedure whereby a health care provider submits a treatment plan to a third party, such as a case manager, before treatment is started. The third party reviews the treatment plan, indicating the patient's eligibility, covered services, amounts payable, application of appropriate deductibles and co-payments and plan maximums.

Point-of-Service Plan (POS)

A type of managed care system that combines features of indemnity plans and HMOs and uses in-network and out-of-network features. A gatekeeper is used to direct an individual to medical care within the network. The covered participant also has the option to received care from any out-of-network provider. If care is received out-of-network, the participant will pay higher co-payments and/or deductibles.

Preferred Provider Organization (PPO)

A group of hospitals and physicians that contract on a fee-for-services basis with employers, insurance companies and other third party administrators, to provide comprehensive medical service. Providers exchange discounted services for increased volume. Participants' out-of-pocket costs are usually lower than under a traditional fee-for-service or indemnity plan. If the network-based health plan has gatekeeper/primary physician requirements, it is not a PPO plan, but a Point of Service (POS) plan.

Self-administered Plan

Refers to a benefit plan in which the company assumes responsibility for full administration of the plan, including claims administration.

Self-funding

A benefit plan funding method in which the employer carries the risk for any claims. The employer may contract with a third party administrator to pay claims in its behalf, or may develop its own department to administer the program.

SET SEG

School Employers Trust and School Employers Group.

Stop-loss provision

A provision in a self-funded plan that is designed to limit an employer's risk of losses to a specific amount. If claim costs (for a month or year or per claim) exceed a predetermined level, an insurance carrier will cover the excess amount.

Third Party Administrator (TPA)

In a health benefit plan, the person or organization with responsibility for plan administration, including claims payment.

Voluntary Employees' Beneficiary Association (VEBA)

A tax-exempt trust established to fund employee welfare benefits other than pensions. Also known as 501(c)(9) trusts, after the section of the Internal Revenue Code authorizing their tax exemption.

Appendix A

List of Respondents

Allegan ISD	Comstock Public Schools
Allendale Public School District	Constantine Public School District
Alma Public Schools	Coopersville Public School District
Armada Area Schools	Copper Country ISD
Athens Area Schools	Corunna Public School District
Bark River-Harris School District	Crawford AuSable Schools
Barry ISD	Crestwood School District
Beal City Public Schools	Davison Community Schools
Bear Lake School District	Dearborn Heights School District #7
Benton Harbor Area Schools	Deckerville Community School District
Benzie County Central Schools	Delta-Schoolcraft ISD
Berkley School District	Detroit City School District
Big Rapids Public Schools	DeWitt Public Schools
Birch Run Area School District	Dowagiac Union School District
Birmingham City School District	Dundee Community Schools
Bloomfield Hills School District	Durand Area Schools
Boyne City Public Schools	East Jordan Public Schools
Branch ISD	East Lansing School District
Brighton Area Schools	Eastern Upper Peninsula ISD
Britton-Macon Area School District	Ellsworth Community School
Bronson Community School District	Engadine Consolidated Schools
Brown City Community Schools	Escanaba Area Public Schools
Bullock Creek School District	Farmington Public School District
Byron Area Schools	Fennville Public Schools
Byron Center Public Schools	Flat Rock Community Schools
C.O.O.R. ISD	Forest Park School District
Calhoun ISD	Fowler Public Schools
Camden-Frontier Schools	Fowlerville Community Schools
Carman-Ainsworth Community Schools	Fruitport Community Schools
Carrollton School District	Galien Township School District
Carson City-Crystal Area Schools	Genesee ISD
Casman Alternative Academy	Gibraltar School District
Cedar Springs Public Schools	Gladstone Area Schools
Center Line Public Schools	Godfrey-Lee Public Schools
Charlevoix Public Schools	Grand Haven Area Public Schools
Charlevoix-Emmet ISD	Grand Ledge Public Schools
Charlotte Public Schools	Grand Rapids Public Schools
Chassell Township School District	Gratiot-Isabella RESD
Chippewa Hills School District	Gull Lake Community Schools
Clare-Gladwin RESD	Gwinn Area Community Schools
Clarkston Community School District	Hale Area Schools
Clawson City School District	Hancock Public Schools
Clinton Community Schools	Hanover-Horton Schools
Clinton County RESA	Harbor Springs School District
Coldwater Community Schools	Harper Creek Community Schools

Appendix A
List of Respondents

Hartland Consolidated Schools	Mason County Central Schools
Haslett Public Schools	Mason Public Schools (Ingham)
Hesperia Community Schools	Mason-Lake ISD
Hillman Community Schools	Mecosta-Osceola ISD
Hillsdale ISD	Melvindale-North Allen Park Schools
Houghton-Portage Township Schools	Menominee ISD
Howell Public Schools	Michigan Center School District
Huron School District	Midland County ESA
Huron Valley Schools	Midland Public Schools
Imlay City Community Schools	Milan Area Schools
Ingham ISD	Mio-AuSable Schools
Inland Lakes Schools	Mona Shores Public School District
Ionia ISD	Montague Area Public Schools
Iron Mountain Public Schools	Montcalm Area ISD
Ishpeming Public School District	Morley Stanwood Community Schools
Jackson ISD	Mt. Pleasant City School District
Jenison Public Schools	Muskegon Area ISD
Kalamazoo R.E.S.A.	Muskegon City School District
Kaleva Norman Dickson School District	Muskegon Heights School District
Kearsley Community Schools	Napoleon Community Schools
Kelloggsville Public Schools	Newaygo County RESA
Kenowa Hills Public Schools	Newaygo Public School District
Kentwood Public Schools	North Dickinson County Schools
Lake City Area School District	Northville Public Schools
Lake Fenton Community Schools	Oceana Intermediate School District
Lake Linden-Hubbell School District	Olivet Community Schools
Lakeshore School District (Berrien)	Orchard View Schools
Lakeview Community Schools (Montcalm)	Oscoda Area Schools
Lakeview Sch. District (Calhoun)	Parchment School District
Lakeville Community Schools	Pennfield School District
L'Anse Creuse Public Schools	Pentwater Public School District
Lansing Public School District	Perry Public School District
Lapeer ISD	Pewamo-Westphalia Community Schools
Lenawee ISD	Pinckney Community Schools
Les Cheneaux Community Schools	Plymouth-Canton Community Schools
Leslie Public Schools	Port Huron Area School District
Lincoln Park Public Schools	Portland Public School District
Lowell Area Schools	Public Schools of Petoskey
Ludington Area School District	Rapid River Public Schools
Mancelona Public Schools	Reading Community Schools
Manistee ISD	Reed City Area Public Schools
Manistique Area Schools	Reese Public Schools
Marion Public Schools	Reeths-Puffer Schools
Marquette Area Public Schools	Richmond Community Schools
Marysville Public Schools	Rochester Community School District

Appendix A
List of Respondents

Rockford Public Schools	Tri County Area Schools
Romulus Community Schools	Troy School District
Saginaw ISD	Tuscola ISD
Saginaw Township Community Schools	Union City Community Schools
Sandusky Community School District	Unionville-Sebewaing Area S.D.
Sault Ste. Marie Area Schools	Utica Community Schools
Shelby Public Schools	Waldron Area Schools
Shiawassee Regional ESD	Walled Lake Consolidated Schools
South Haven Public Schools	Waterford School District
South Lake Schools	Wayne RESA
South Lyon Community Schools	Wayne-Westland Community School District
Spring Lake Public Schools	West Bloomfield School District
St. Joseph County ISD	Westwood Community Schools
St. Louis Public Schools	White Cloud Public Schools
Standish-Sterling Community Schools	White Pigeon Community Schools
Stephenson Area Public Schools	Whiteford Agricultural Schools
Stockbridge Community Schools	Whitehall District Schools
Sturgis Public Schools	Whitmore Lake Public Schools
Summerfield School District	Willow Run Community Schools
Superior Central Schools	Wyandotte City School District
Swartz Creek Community Schools	Wyoming Public Schools
Three Rivers Community Schools	Yale Public Schools
Traverse City Area Public Schools	
Trenton Public Schools	

Michigan Public Schools

Health Care Benefits Survey

Completed by School Districts

Completed by: Name:

Phone:

Title:

Michigan 5-digit School District Code:

County:

What is the name of your ISD / RESA: (Please select from the drop down list)

A to H:

I to O:

P to Z:

Address:

City, State, Zip:

Fax:

E-mail:

Complete data submission due *May 16, 2005*

- No individual school district data will be released -

HayGroup

Please Send Completed Surveys to:

Sanjit Puri
Hay Group, Inc.
4301 N. Fairfax Drive, Suite 500
Arlington, VA 22203
FAX: (703) 908-3000
Email: sanjit_puri@haygroup.com

General Instructions

- This questionnaire asks for general information about your health care benefit plans (medical, prescription, dental, and vision) that is not normally found in Summary Plan Descriptions.
- Any additional information that is relevant to this survey can be written in the margins of the questionnaire or provided on separate sheets of paper.
- In addition to the information that will be collected in this survey, we will also need a copy of the health benefit plans. Therefore please mail a copy of the SUMMARY PLAN DESCRIPTIONS, PLAN DOCUMENTS, OR ANNOUNCEMENT BULLETINS DESCRIBING YOUR MEDICAL, PRESCRIPTION, DENTAL AND VISION BENEFIT PLANS OR POLICIES IN DETAIL. IF MATERIAL IS OUTDATED, PLEASE MAKE HANDWRITTEN CORRECTIONS OR PROVIDE SUPPLEMENTAL EXPLANATIONS.

If your prevalent medical plan (that is the medical plan with the highest enrollment) is a MESSA plan, a SET-SEG plan, or a MEBS plan, we will not need the medical plan document.

- If you have any questions, please contact Sanjit Puri by e-mail at Sanjit_Puri@haygroup.com or by telephone at (703) 841-3179 or Tom Wildsmith at Tom_Wildsmith@haygroup.com or at (703) 841-3135.
- PLEASE RETURN COMPLETED SURVEY AND ALL REQUESTED BENEFIT PLAN BOOKLETS TO:

Sanjit Puri Hay Group, Inc. 4301 N. Fairfax Drive, Suite 500 Arlington, VA 22203 FAX: (703) 908-3000 Email: sanjit_puri@haygroup.com

Definitions used in the survey

Fee-for-Service (FFS) a traditional indemnity plan that provides designated reimbursement to covered persons for designated health services. The insured is able to choose the provider without penalty. All providers of the same service are reimbursed at the same level; i.e., there are no "preferred" or "exclusive" providers. There may be a hospital pre-certification requirement as well as catastrophic case management. The plan can be fully or partially insured or self-insured.

Health Maintenance Organization (HMO) – a managed care plan in which the individual must go through a "gatekeeper" primary physician for all medical care. The gatekeeper refers the individual to a provider within the network if specialization is needed. There is no benefit provided out-of-network.

Preferred Provider Organization (PPO) – a medical plan that allows the employee to decide between a network of preferred providers (hospitals and/or physicians) with higher reimbursement levels and out-of-network providers each time service is to be provided. If the network has gatekeeper/primary physician requirements, it is not a PPO, but a POS.

Point-of-Service (POS) - also called open-ended HMOs. A medical plan that allows the employee to decide between a network of gatekeeper managed care providers or indemnity plan with higher employee co pays each time the service is to be provided.

Michigan Public Schools Health Care Benefits Survey

1.b Please provide a list of all the Dental and Vision plans, that your school district offers to all your public school employees (e.g. including, instructional staff, instructional aides, administrative staff, support staff, others). You may provide the information in the table below or in a separate attachment.

Enter the name of the health plan in the space provided. Under the "Type" specify the plan type (FFS, Dental HMO, Other)

Dental Plan										
Name of Plan (E.G. Delta Dental))	Type	Enrollment			Total Monthly Premium ²⁵			Monthly Employee Contribution		
		Single	Two Party	Family	Single	Two Party	Family	Single	Two Party	Family

Vision Plan									
Name of Plan (E.G. VBA)	Enrollment			Total Monthly Premium ³			Monthly Employee Contribution		
	Single	Two Party	Family	Single	Two Party	Family	Single	Two Party	Family

²⁵ Total monthly premium is the total of, Paid by employee and Paid by the school district

Michigan Public Schools Health Care Benefits Survey

2. Who is eligible to enroll in the health care plans (Medical, Prescription, Dental, and Vision) regardless of who pays all or part of the premium? Enter the information in the spaces provided.

Medical Plans	Enter Hours or days as Applicable for An Employee to be Eligible for Coverage	
Employee Classification	Hours per Day	Days Per year
Professional / Instructional Staff	<input type="text"/>	<input type="text"/>
Instructional Aides	<input type="text"/>	<input type="text"/>
Administrative Staff (executive/ administrator)	<input type="text"/>	<input type="text"/>
Clerical Staff	<input type="text"/>	<input type="text"/>
Transportation staff	<input type="text"/>	<input type="text"/>
Food Service staff	<input type="text"/>	<input type="text"/>
Custodial / Maintenance Staff	<input type="text"/>	<input type="text"/>
Others Please Specify. <input type="text"/>	<input type="text"/>	<input type="text"/>

2. a. If you don't have a stand alone dental plan, skip to 2.b

Dental Plans	Enter Hours or days as Applicable for An Employee to be Eligible for Coverage	
Employee Classification	Hours per Day	Days Per year
Professional / Instructional Staff	<input type="text"/>	<input type="text"/>
Instructional Aides	<input type="text"/>	<input type="text"/>
Administrative Staff (executive/ administrator)	<input type="text"/>	<input type="text"/>
Clerical Staff	<input type="text"/>	<input type="text"/>
Transportation staff	<input type="text"/>	<input type="text"/>
Food Service staff	<input type="text"/>	<input type="text"/>
Custodial / Maintenance Staff	<input type="text"/>	<input type="text"/>
Others Please Specify. <input type="text"/>	<input type="text"/>	<input type="text"/>

2. b. If you don't have a stand alone vision plan, skip to 3

Vision Plans	Enter Hours or days as Applicable for An Employee to be Eligible for Coverage	
Employee Classification	Hours per Day	Days Per year
Professional / Instructional Staff	<input type="text"/>	<input type="text"/>
Instructional Aides	<input type="text"/>	<input type="text"/>
Administrative Staff (executive/ administrator)	<input type="text"/>	<input type="text"/>
Clerical Staff	<input type="text"/>	<input type="text"/>
Transportation staff	<input type="text"/>	<input type="text"/>
Food Service staff	<input type="text"/>	<input type="text"/>
Custodial / Maintenance Staff	<input type="text"/>	<input type="text"/>
Others Please Specify. <input type="text"/>	<input type="text"/>	<input type="text"/>

Michigan Public Schools Health Care Benefits Survey

PART B

Please answer Questions in Part B using the primary health plan; that is, the health plan with the highest enrollment for your school district.
Your Primary Health Plan is the Medical Plan with the highest enrollment, as entered on the first page. (See your answer to Question 1.)

3. What is the name of the primary health plan?

4. Who administers the primary health plan?

	Medical	Prescription	Dental	Vision
Not offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BCBS Michigan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Insurance Company	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Michigan Education Special Services Association (MESSA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Michigan Employee Benefit Services (MEBS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Michigan Association of School Boards (SET-SEG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Third Party Administrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-house/self-administered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Union / Taft-Hartley Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. If you have a self-insured health plan, please provide the following information.

	Current Plan year	Last Year
Individual Stop Loss	<input type="text"/>	<input type="text"/>
Individual Stop Loss Level (e.g. \$50,000)	<input type="text"/>	<input type="text"/>
Monthly Premium for Individual Stop Loss		
On a per employee basis or	<input type="text"/>	<input type="text"/>
On a per covered life basis	<input type="text"/>	<input type="text"/>
Aggregate Stop Loss	<input type="text"/>	<input type="text"/>
Aggregate Level (e.g., 125%)	<input type="text"/>	<input type="text"/>
Monthly Premium for Aggregate Stop Loss		
On a per employee basis or	<input type="text"/>	<input type="text"/>
On a per covered life basis	<input type="text"/>	<input type="text"/>

Prescription Drug Coverage

6. Does your prescription plan utilize a formulary? If no skip to question 8.

Definitions:

Formulary - a list of drugs selected by a health plan identified as safe, effective and lower cost than non-formulary drugs.

Open Formulary – coverage provided for all drugs

Closed Formulary – non-formulary drugs are not covered by the health plan

- ☐ Yes
☐ No

Michigan Public Schools Health Care Benefits Survey

7. If your health plan uses a formulary, is it an open formulary or a closed formulary?

- ☐ Open
☐ Closed

8. Does your prescription drug program include a mail order plan? If no skip to question 10.

- ☐ Yes, mail order in addition to retail
☐ Yes, mail order only
☐ No mail order plan

9. If mail order plan is offered, is it mandatory for maintenance (long-term) prescriptions?

- ☐ Yes, mandatory for maintenance prescriptions
☐ No

Mental Health and Substance Abuse Care

10. Do you have a stand alone or carved-out mental health plan (not an Employee Assistance Program) that is one in which mental health services are covered under a separate contract by a specialty vendor instead of under regular medical covered services.

- ☐ Yes, inpatient only
☐ Yes, outpatient only
☐ Yes, both
☐ Yes, other
☐ Not a carved-out benefit

Case Management

Catastrophic case management involves active management of medical services for very ill persons with the objective of facilitating hospital discharge, thus enabling patients to receive lower cost care in an extended care facility or home health care program.

Disease management attempts to minimize the costs associated with conditions such as asthma, diabetes, hypertension, and high risk pregnancies to name a few.

11. Does your school district sponsor a case management program for your health plan? If no skip to question 14.

- ☐ Yes
☐ No

12. Does your organization's case management program include:

	Yes	No
Large Case Management	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Care Management	<input type="checkbox"/>	<input type="checkbox"/>
Specific Disease Management	<input type="checkbox"/>	<input type="checkbox"/>

13. Who administers your case management programs? (Check all that apply)

Michigan Public Schools Health Care Benefits Survey

- ☐ Insurance company
- ☐ Third-party administrator
- ☐ Self-administered
- ☐ Other, Please Specify

Waiver of Health Coverage

14. Can employees receive cash incentives, bonuses, or other credits in lieu of enrolling in or in exchange for opting out of your group health care plan?

- ☐ Yes, can receive cash or other credits
- ☐ No

15. Can employees receive cash incentives, bonuses, or other credits in lieu of enrolling in or in exchange for opting out of your group dental plan?

- ☐ Yes, can receive cash or other credits
- ☐ No

16. If employees receive cash or other credits in lieu of enrolling in or in exchange for opting out of coverage, what is the amount?

Note: if the amount varies by classification of employee, please provide the information for just the Professional and Instructional Staff.

- ☐ Full value of premium
- ☐ Percentage of premium %
- ☐ Flat dollar amount (per year)

\$ for medical coverage

\$ for dental coverage

- ☐ Other, specify:

Is the amount the same for all classes of employees?

- ☐ Yes, same for all classes
- ☐ No

17. Does your organization allow employees to enroll their spouses in your medical plan even if the spouse could have medical coverage through his/her own employer?

- ☐ Yes, although additional premium is imposed as a penalty
- ☐ Yes, with no penalty
- ☐ No, does not allow it

Part C

Administration/Management of Health Plans

18. Do you use the services of a health insurance consultant / broker for purpose of assisting you in obtaining health care benefits?

Michigan Public Schools Health Care Benefits Survey

- ☐ Yes
☐ No

19. Please describe the services your broker provides in regards to your health care plans?

20. How many full-time equivalent employees are dedicated to the administrative and management tasks of the health care plans?

Specify number of full-time equivalent employees:

21. If the health benefits are subject to collective bargaining, what is the date of the next Collective Bargaining Agreement?

Please Send Completed Surveys to:

Sanjit Puri
Hay Group, Inc.
4301 N. Fairfax Drive, Suite 500
Arlington, VA 22203
FAX: (703) 908-3000
Email: sanjit_puri@haygroup.com

Surveys are due May 16, 2005

Appendix C

Actuarial Assumptions and Methodology

Documentation of Assumed Cost Savings

The anticipated system-wide cost savings were comprised of three main areas: administration, purchasing, and financing. Administration savings were developed from eligibility management, including daily updates on eligibility changes, positive certification of spousal coverage and recertification of student eligibility. Purchasing savings are achieved primarily through using the purchasing power of the plan, carving out specific benefit coverages and separately bidding and managing the contracts. Purchasing savings would also include negotiated provider access fees and administrative services only (ASO) contract charges. Financing savings are achieved by moving to a self-funded plan, avoiding stop-loss premiums and commission costs.

Frequent Eligibility Updates

Current administration of most groups includes a two-month grace period of coverage after termination. Best practices administration would provide frequent updates to the carriers and allow the carrier a short grace period after receipt of the eligibility changes. The plan would then not be responsible for the cost of services provided to ineligible people. Based on the assumptions used for the MPSERS valuation, annual turnover of school employees varies from 35 percent in the first year of employment to under 4 percent for employees with over 5 years of service. On average, about 6 percent of employees terminate in a year. Using this rate for employees and slightly higher rates for dependents produced an average termination rate of 7.22 percent. Terminating employees are 4 years younger on average than the overall school employee population and can be expected to have 14 percent lower costs. Moving to weekly enrollment / disenrollment updates would reduce covered days by 53 days for 54 percent of the group, 23 days, for 31 percent of the group, and no change for 15 percent, resulting in an average reduction of 36 days.

A = Average expected to terminate coverage annually = 7.22%

B = Reduction in days of coverage moving from current to best practices = 36/365

C = Health care costs terminating employees as a percent of average costs = 8.6%

D = Annual savings percent = $A \times B \times C = 0.65\%$

Twice-yearly Student Certification

Data from the Commonwealth of Pennsylvania shows that about 16 percent of students are decertified following information received from a parental letter sent at the beginning of the school year requesting the name of the college the student is attending, if any, and a further 19 percent of students are decertified based on information received from the named college from a letter sent at the end of the first semester. We assumed that the number of college-aged students in Michigan will be similar to Pennsylvania where the average is 90 college-aged students per 1,000 school employees. The average health care cost per 19-25 year old Michigan dependent is \$1,735. All of the administrators issue annual “parental” letters, however few of the current administrators sought information from colleges. The decertification from coverage based on college data would remove coverage for half a year on average. The system-wide savings from

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using twice-yearly student eligibility certification, after allowing for increased administration cost of processing the letters is \$2,647,000 or 0.14 percent of the total cost.

A = number of Michigan school employees = 190,000

B = number of 19-25 year old students per 1,000 school employees = 90

C = percent of students decertified based on data from the college = 19%

D = average annual medical cost of coverage per 19-25 year student = \$1,735

E = gross annual savings = $A \times B / 1000 \times C \times 50\% \times D = \$2,818,000$

F = higher administration cost = $\$10 \times 17,100 \text{ letters} = \$171,000$

G = net annual savings = $E - F = \$2,647,000$

H = FY 2004-05 aggregate medical plan cost = \$1,932,000,000

I = Annual savings percent = $G / H = 0.14\%$

Self-Funding

A large self-funded health plan will be relieved from paying stop-loss insurance premiums, contributions to reserves and state mandated subsidies. In addition, a self-funded plan would avoid paying commissions to agents or brokers for placing the coverage.

Stop-Loss Insurance

BCBSM reported stop loss premiums for ASC school customers of \$6,490,000 for 21,700 contracts. Data in the school surveys reported a total of individual and aggregate stop-loss premiums of \$6,400,000 for 17,200 employees. System-wide, we estimate the total stop-loss premiums currently incurred are \$8,060,000. A significant portion of this cost funds claims above the individual or aggregate stop-loss limits, however, about 40 percent is used to cover commissions, expenses, risk charges and profit/contribution to reserves. A system-wide health plan would not need stop-loss insurance, resulting in savings of \$3,224,000, or 0.17 percent of total cost.

A = Aggregate stop-loss premiums incurred in 2004/05 = \$8,060,000

B = Portion of premiums not used to fund benefits = 40%

C = Annual savings = $A \times B = \$3,224,000$

D = FY 2004-05 aggregate medical plan cost = \$1,932,000,000

E = Annual savings percent = $C / D = 0.17\%$

Insurer Gain and State Mandated Subsidies

When pricing fully insured health benefits, insurers include in their premiums a margin in excess of expected benefit costs and expenses. If actual benefit costs are equal to the level expected, this margin becomes a gain for the insurer. For commercial insurers, it provides the profit demanded by investors. For non-profit companies, which do not have the same access to capital markets, it provides a source for the capital and surplus necessary to maintain the financial soundness of the insurance operation and finance growth of the organization. A variety of terms

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are used to describe this margin, including profit, contribution to surplus, and contribution to reserves (i.e., referring to reserved capital, and not incurred but not reported claim reserves).

The small group, experience rated groups, and MESSA plans administered by BCBSM were levied a contribution to reserves and were required to contribute towards state mandated subsidies. A self-funded plan would avoid these charges.

TABLE C.1			
Determination of Savings from Self-Funding			
Group	Enrollment	Contribution to Reserves	Mandated Subsidies
1. Small Group Employers	7,696	2.60%	1.40%
2. Experienced Rated	10,560	3.30%	1.50%
3. MESSA	97,977	2.00%	1.00%
4. Self-funded	24,063	0.00%	0.00%
5. Weighted Average	140,296	1.79%	0.89%
6. Non HMO coverage		86%	86%
7. System-wide Savings from self-funding		1.54%	0.77%

Commissions

The small group insurance contracts with BCBSM include agent commissions. A state-wide system would avoid this expense. About 5 percent of the covered lives currently have their coverage arranged through agents incurring agent commissions. System wide, this cost represents 0.16 percent of the total cost.

A = Percent of coverage arranged through agents = 5 %

B = Average agent commissions = 3.3%

C = Savings from avoidance of commissions = $A \times B = 0.16\%$

The total savings from self-funding the health care coverage is 2.64%, comprised of the following elements:

A = Stop-loss savings = 0.17%

B = Contribution to reserves savings = 1.54%

C = Mandated subsidies savings = 0.77%

D = Commissions savings = 0.16%

E = Total Self-funding savings = $(A + B + C + D) = 2.64\%$

Carve-outs

Pharmacy Benefits

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The survey data reported that only 15 percent of employees receive their pharmacy benefits through a carved out prescription drug plan. Pooling all prescription drug coverage, including that provided by HMOs, into one contract will enable the plan to bid this coverage competitively and obtain lower rates. We compared the cost of the pharmacy coverage as a percent of total medical costs for districts that carved out the pharmacy benefits to those that have not and found the current arrangements had lowered the pharmacy cost by 20 percent for the groups that carved out the coverage. Furthermore, recent bidding experience of a similar sized state-wide system produced guaranteed lower costs in excess of 25 percent. Michigan could anticipate saving at least 15 percent of the current pharmacy expenditure by carving out and bidding the benefit with tiered coverage and administration arrangements similar to the current arrangements. Higher level of savings could be achieved with the use of the full array of pharmacy benefit management approaches (e.g. requiring mandatory generics and mail order of maintenance drugs).

A = Pharmacy expenses as a percent of total health care costs = 22.4%

B = Reduction in pharmacy costs from pooling and bidding the coverage = 15%

C = Savings in total health care costs from carving out pharmacy coverage = $A \times B = 3.36\%$

This level of savings could only be achieved by having a uniform set of benefits across all plans. If a PBM had to administer the array of current benefit levels, we estimate the reduction in pharmacy costs would be 10 percent after absorbing higher administration costs. Therefore under Option 1, the level of savings would be 2.24 percent.

Durable Medical Equipment

Our recent experience shows that pooling all DME purchases into one contract produced savings in DME equivalent to 0.20 percent of total health care expenses.

Mental Health & Substance Abuse

Blue Cross and Blue Shield of Michigan has subcontracted with Magellan to manage the MHSA benefits, using BCBSM negotiated rates. This arrangement mirrors the utilization and cost management outcomes that are usually achieved from a carve-out. We did not analyze whether a separately negotiated contract would generate savings.

Administrative

We were provided with data from Blue Cross Blue Shield of Michigan that showed the following administrative costs by type of group:²⁶

²⁶ These do not include contributions to reserves or certain required subsidy charges.

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TABLE C.2 Administrative Fees					
	Small Group	Experience Rated	MESSA	Self Funded	Overall Average
Employees	7,696	10,560	97,977	24,063	140,296
Current fees	8.6%	8.6%	7.5%	6.2%	7.43%
Option 1	7.5%	7.5%	7.5%	6.2%	7.30%
Options 2 & 3	6.0%	6.0%	6.0%	6.0%	6.00%

Self-funded ASC groups are charged a monthly administration fee. The most recent data showed the administration fees for 53,323 members covered under administrative service only contracts were \$10,280,889 on a claims volume of \$166,015,150, or a fee of 6.2 percent.

A state-wide self-funded system covering 380,000 covered lives with 5-7 plan designs should be able to negotiate the administration charge to be slightly lower than that for groups covering 53,000 lives. We anticipate the administration charge for these options to be 6.0 percent. The weighted average administration charge currently is 7.43 percent. These savings would only apply to the 86 percent of employees not in HMO plans, so the system-wide savings would be 1.23 percent.

Under Option 1, with dozens of different plan designs to administer, the administration savings should mirror those achieved by MESSA. Accordingly, we have assumed that the current level of fees charged for the MESSA plans would apply to the small group and experience rated plans. These fees produce a weighted average of 7.30%, resulting in system-wide savings of 0.11 percent.

Provider Access Fees

Based on data provided by BCBSM, the ASC schools provider access fees are currently \$39.10 per contract. The state-wide Civil Service plan had negotiated provider access fees of \$22.50 per contract per month in 2002/03, with contractual increases of 3% per year (plus an allowance for annual increases in utilization). As a state-wide school employees plan has a larger membership than the Civil Service plan, it should be able to negotiate a provider access fee at least as favorable. Assuming the fee is \$24.81 per contract per month in 2004/05, this results in savings of \$12,243,000, if 38 percent of the coverage is through PPO plans (under Options 1 & 2) and \$27,660,000 if 85 percent of the coverage is through PPO contracts (under Option 3).

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A = current provider access fee = \$39.10 per contract
 B = negotiated provider access fee = \$24.81 per contract
 C = reduction in provider access fee = A – B = \$14.29
 D = number of contracts currently = 71,400 (Options 1 & 2)
 E = number of contracts in a state-wide plan = 161,300 (Option 3)
 F = annual savings percent = C x 12 x D / \$1,932,000,000 = 0.63%
 G = annual savings (Option 3) = C x 12 x E / \$1,932,000,000 = 1.43%

Audits

As a self-funded plan, audits that identify ineligible charges will, when adjudicated, result in direct savings to the plan. Experience from other large systems indicates a range of possible savings. Net of the cost of the audit, we estimate the savings to be 0.10 percent of claims.

Table C-3 summarizes the savings under each of the options.

TABLE C.3 Summary of Savings by Option			
	Option 1	Option 2	Option 3
Eligibility Management			
• Frequent update	0.65%	0.65%	0.65%
• Student eligibility	<u>0.14%</u>	<u>0.14%</u>	<u>0.14%</u>
	0.79%	0.79%	0.79%
Self Funding			
• Insurer Gain	1.54%	1.54%	1.54%
• Stop-loss premium	0.17%	0.17%	0.17%
• Commissions	0.16%	0.16%	0.16%
• Subsidies	<u>0.77%</u>	<u>0.77%</u>	<u>0.77%</u>
	2.64%	2.64%	2.64%
Purchasing			
• Negotiated admin fees	0.11%	1.23%	1.23%
• Provider access fees	0.63%	0.63%	1.43%
• Pharmacy carve-out	2.24%	3.36%	3.36%
• DME carve-out	0.20%	0.20%	0.20%
• Audits	<u>0.10%</u>	<u>0.10%</u>	<u>0.10%</u>
	3.28%	5.52%	6.32%
Total	6.71%	8.95%	9.75%

Benefit Value Comparison

Hay Group has developed a technique of “common costs” that permits the assignment of dollar values using a common yardstick across all employers in the comparator group. Hay Group uses its proprietary Benefit Value Comparison (BVC) model to calculate quantitative values and the competitive position of an employer’s benefit plan(s).

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BVCs are computed using a common set of assumptions about demographic, geographic, and economic factors that isolate differences in benefit values as being solely attributable to differences in plan design. The resulting benefit values permit objective “apples-to-apples” comparisons of the benefit programs provided by various employers. Differences in benefit values for the employer plans being compared can be traced directly to design differences.

Benefit values are based on the average cost of providing the benefits to employees for a typical large U.S. employer. Valuations take into account the expected frequency and duration of use of a benefit.

The key to the Hay “common cost” approach is the use of a single, realistic method for all plans being valued. All plans in the study are, in effect, “purchased” for the same group of employees from the same source using the same financing technique. The “employees” are a typical mix of employees that might be found working for a large employer. The “providers” are a hypothetical group of insurance companies and/or trustees who are “selling” coverage using the same average group rates, actuarial assumptions, and experience ratings for all the plans in the study. The result is an actuarially derived “common cost” for each plan, expressed as a dollar value.

Health Care Trends Rates

The baseline claims costs used in the analysis were for FY2004-05. Table C.4 shows the rates used for projections after June 30, 2005.

TABLE C.4		
Year	Health Care Cost	Administration Cost
FY 2005-06	12%	2%
FY 2006-07	8%	2%
FY 2007-08	6%	2%
FY 2008-09	5%	2%
FY 2009-10	5%	2%

Appendix D

Michigan Health Maintenance Organizations

Based on information reported from the Michigan Office of Financial and Insurance Office (OFIS), there are 12 HMO's with commercial populations over 3,000 operating in Michigan (This count does not include HMO's with a Medicaid-only population). The 12 HMOs are:

- Aetna Health, Inc –Michigan
- Blue Care Network of Michigan
- Care Choices HMO
- Grand Valley Health Plan, Inc.
- Health Alliance Plan of Michigan
- HealthPlus of Michigan, Inc.
- M-CARE, Inc.
- Priority Health
- Physicians Health Plan of Mid-Michigan
- Physicians Health of South Michigan
- Physicians Health Plan of Southwest Michigan, Inc.
- Total Health Care, Inc.

Of these 12 HMO's, Blue Care of Michigan and Priority Health have the broadest coverage and are authorized to operate in the most counties. Blue Care operates across all of 50 Michigan counties, and across parts of 12 other counties. Their total group enrollment exceeds 457,000. Priority Health enrollment is near 370,000 and has networks across all of 20 counties and parts of 11 other counties. Although not operating in as many counties, Health Alliance of Michigan also has one of the largest Michigan group HMO enrollments (380,000). With the exception of M-Care (176,000) and Care Choices (103,000) the remaining HMO's discussed have enrollments of less than 100,000.

TABLE D.1	
Largest Michigan HMO Enrollments	
Blue Care	457,000
Health Alliance of Michigan	380,000
Priority Health	367,000
M-CARE	176,000
Care Choices	103,000

The OFIS provides an HMO Consumer Guide on its web-site which provides information regarding the quality of care at Michigan HMO's. The Consumer Guide also indicates plan enrollment, profit or non-profit status, the number of consumer complaints, accreditation ratings and financial information. Some of the information presented in the OFIS Consumer Guide was compiled in conjunction with the Coordinated Autos/UAW Reporting System (CARS) project

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and National Committee for Quality Assurance (NCQA).²⁷ The following is a brief overview of the key quality findings indicated for the above HMOs. The NCQA accreditation levels reported below are based on the HMO's accreditation status as of the 4th quarter of 2004.

- All but Aetna, Physicians Health Plan of South Michigan, Physicians Health Plan of Southwest Michigan and Total Health Care, Inc. received an “excellent” NCQA rating.
- HealthPlus of Michigan received an above average and Priority Health a considerably above average consumer rating with regard to access to care and customer service.
- Priority Health was the only HMO to receive an above average consumer rating for physician communications and service.
- Care Choices, HealthPlus, M-Care and Priority Care received the highest rating for how often they provided preventive care.
- Several of the HMO's received above average ratings for how well they take care of their members who have health problems. Care Choices, Health Alliance and M-Care received a ranking that was considerably above average, the top ranking level.

TABLE D.2				
Health Maintenance Organizations in Michigan				
Name of HMO	Group Enrollment	Approved Regions	Profit/Not-for Profit Status	NCQA* Accreditation
Aetna Health, Inc.-Michigan	2,941	Macomb, St. Clair, Wayne plus part of Monroe and Oakland County	For Profit	No NCQA Accreditation Reported
Blue Care Network of Michigan	457,280	50 full Counties plus 12 partial Counties	Non-Profit	Excellent
Care Choices	102,752	Clinton, Ottawa, Eaton, Washtenaw, Kent, Livingston, Muskegon plus 11 partial Counties	Non-Profit	Excellent
Grand Valley Health Plan	14,425	Allegan, Ionia, Kent, Ottawa	For-Profit	Excellent
Health Alliance Plan of Michigan	380,589	Genesee, St Clair, Livingston, Washtenaw, Oakland, Wayne, Macomb, Monroe plus partial approval for Lapeer, Saginaw, Sanilac, Shiawassee Counties	Non-Profit	Excellent

²⁷ The CARS project is a joint effort sponsored by the three U.S. auto companies, the United Auto Workers, the Greater Detroit Area Health Council and the United Auto Workers. The goal is to provided coordinated quality measurement and reporting.

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TABLE D.2				
Health Maintenance Organizations in Michigan				
Name of HMO	Group Enrollment	Approved Regions	Profit/Not-for Profit Status	NCQA* Accreditation
HealthPlus of Michigan	85,714	Arenac, Bay, Genesee, Iosco, Lapeer, Livingston, Saginaw, Shiawassee, Tuscola plus approval for 5 partial Counties	Non-Profit	Excellent
M-CARE	175,966	Genesee, Livingston, Macomb, Oakland, Washtenaw plus partial approval for Ingham, Jackson, Lapeer, Monroe and St. Clair Counties	Non-Profit	Excellent
Physicians Health Plan of Mid-Michigan	67,774	Clinton, Eaton, Gratiot, Ionia, Montcalm, Shiawassee plus partial approval for Ingham, Isabella, Saginaw Counties	Non-Profit	Excellent
Physicians Health Plan of South Michigan	28,709	Hillsdale, Jackson, Washtenaw and partial approval for Calhoun, Ingham, Lenawee, Livingston Counties	Non-Profit	Scheduled for review
Physicians Health Plan of Southwest Michigan	1,617	Allegan, Barry, Berrien, Branch, Cass, Kalamazoo, St. Joseph, Van Buren and partial approval for Calhoun County	Non-Profit	Pending
Priority Health	367,276	Full Approval for 20 Counties and partial approval for 11 Counties	Non-Profit	Excellent
Total Health Care	10,479	Macomb, Oakland, Wayne and partial approval for Genesee, Lapeer and St. Clair Counties	Non-Profit	No NCQA Accreditation (JCAHO and AAAHC Accreditation)

*NCQA Accreditation Reported as of fourth quarter of 2004